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# **Neglected Tropical Disease Control Program**

Semi-annual Report,  
April 1, 2008–September 30, 2008

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# Neglected Tropical Disease Control Program

Semi-annual Report, April 1, 2008–September 30, 2008

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## List of Acronyms

APOC	African Programme for Onchocerciasis Control
APS	Annual Program Statement
CDC	Center for Disease Control
EOI	Expression of Interest
ES	Exit Strategy
GWU	George Washington University
ITI	International Trachoma Initiative
IRs	Intermediate Results
LATH	Liverpool Associates in Tropical Health
LF	Lymphatic Filariasis
LOA	Letter of Authorization
M&E	Monitoring and Evaluation
MDA	Mass Drug Administration
MOH	Ministry of Health
NGO	Non-Governmental Organization
NTD	Neglected Tropical Disease
PCT	Preventive Chemotherapy
PDCI	Partnership for Disease Control Initiatives
RFA	Request for Application
RTI	RTI International
SCI	Schistosomiasis Control Initiative, Imperial College, London
SP	Sustainability Planning
STH	Soil-Transmitted Helminthes
TAG	Technical Advisory Group
USAID	United States Agency for International Development
WHO	World Health Organization

# 1. Summary

During the second half of Year 2, the Program finalized and obtained approval for its Year 2 Work Plan and Budget, completed the initial draft of its Year 3 Work Plan and Budget, and filled two positions vacated by their incumbents. As in Year 1, the Program made a number of important contributions to the state-of-the-art in area of monitoring and evaluation, as is evidenced by the fact that its work will be featured in two presentations at the upcoming American Society of Tropical Medicine and Hygiene annual conference.

Implementation of integrated NTD programs in Year 2 took place in eight countries: Burkina Faso, Ghana, Mali, Niger, Uganda, Haiti, Southern Sudan and Sierra Leone. During the Program's work planning meeting in January the team jointly determined that due to the fact that the Program's new funding for Year 2 was limited to only a slight increase over funding for Year 1, while three new countries has been added, funding for the first five country programs would remain constant. Thus, scale up for increased coverage resulted from budget efficiencies rather than increased funds.

The three new country programs selected (Haiti, Southern Sudan and Sierra Leone) faced serious challenges to implementation due to hurricanes, post-conflict settings, security concerns, weak government infrastructure and high cost of operating in these settings. Stakeholders meetings were held in Haiti and Sierra during the second quarter of Year 2, and in Southern Sudan the meeting was held in May 2008. MDA is being conducted in the first quarter of Year 3 in both Haiti and Sierra Leone, and integrated mapping is planned for the first half of Year 3 in Southern Sudan.

Highlights of Year 2 achievements under the Program's Direct Implementation component are summarized below. At this time all data are preliminary and based on reported coverage information. Data will be updated and finalized following the conduct of post-MDA validation surveys.

## *Coverage*

**In Year 2 the Program successfully delivered approximately 57 million treatments to over 27 million people in four countries** (Burkina Faso, Mali, Niger, and Uganda). During the first 2 years of the program over 90 million treatments were provided to 30 million people, over half of the NTD Control Program's life of project goal of 160 million treatments provided to 40 million people.

During the second year of implementation the NTD Control Program successfully initiated mass drug administration campaigns in seven countries, and successfully completed the campaigns in four (Niger, Burkina Faso, Mali and Uganda). Three additional MDAs are taking place in Haiti, Ghana and Sierra Leone in the first quarter of Year 3. Also during Year 2, preparations for MDAs in three additional countries were undertaken. The MDAs in Haiti, Ghana and Sierra Leone will

take place during the first quarter of Year 3, targeting approximately 10 million additional people, who will be counted in Year 3 reports.

During Year 2 country programs achieved coverage rates of over 80% of the population eligible for treatment.

#### *Additionality*

Despite the fact that only four of the eight countries completed MDAs during the Year 2 and the NTD Control Program received only a marginal increase in the overall level of funding, during its second year the Program achieved significant in the following areas: mapping of new geographic areas; number of people treated; number of treatments provided; and number of implementation units (geographic) targeted for treatment.

The Program supported the distribution of over \$590 million worth of donated drugs during Year 2.

#### *Capacity Building*

During Year 2 NTD Control Program partners provided training to over 200,000 workers at central, regional and district levels.

#### *Sustainability*

During Year 2, the Program took many significant steps toward ensuring government ownership and leadership of their national NTD control programs, building on the lessons learned by the Program in Year 1 and guided by the results of the global assessment of NTD programs conducted by WHO in the first quarter of Year 2. In all NTD Control Program participating countries, the role of the grantees as being **supporters** rather than implementers of the national programs was emphasized during the reporting period, to assure strong government ownership of the country programs.

A total of \$5.3 million of praziquantel and albendazole were procured by the NTD Control Program in Year 2; \$2.6 million for distribution in Year 2 and \$2.7 million for distribution in Year 3. To allow the Program to expand to include a number of countries in Asia, we submitted a request for a waiver to procure DEC and mebendazole, which was successfully obtained in October 2008.

A Request for Application for new partners for the Neglected Tropical Disease (NTD) Control Program in Asia was released on June 16, 2008 for the following countries: Afghanistan, Bangladesh, Burma, Cambodia, East Timor, India, Indonesia, Lao (PDR), Nepal, Pakistan, Papua New Guinea, Philippines, Sri Lanka, Vietnam, and Yemen. Six applications for programs in India, Nepal, Bangladesh, Cambodia, PDR Laos and Vietnam and Philippines were received by the deadline of July 31, 2008. A rigorous two-stage technical review process resulted in the selection the British Leprosy Relief Association (LEPRA) to coordinate and monitor the distribution of medicines in Bangladesh and Nepal.

The Program continued to provide daily and weekly support to grant partners across numerous areas by the NTD Control Program team: managing US government funds, integrating neglected tropical diseases, mapping and MDA implementation, supporting governments as owners of the process including providing funds and achieving additionality. Grants management under the NTD Control Program is partnership building through a social process of building mutual trust, common goals and a sense of one team working together to overcome challenges, find innovations, define sustainable exit strategies that include leveraging resources and reducing costs. This process takes time, and during this reporting period some achievement towards both legal and financial compliance and partnership building on all of the above took place.

At USAID's request the Program focused considerable effort on actively supporting USAID and WHO as they prepared for the Meeting of the Stakeholders in the Presidential NTD Initiative. In addition to assisting with meeting logistics, including sponsoring 20 participants from developing countries around the world, the NTD Control Program contributed extensively to the development of the 4 working papers prepared for discussion at the Meeting. In particular, the Program made major contributions to the Working Paper on Monitoring and Evaluation, authored by WHO, co-sponsored with CDC the early September meeting held in Atlanta to further develop the CDC-authored Working Paper on Operational Research, and commented extensively on the Working Paper on Country Selection authored by USAID.

The second half of Year 2 saw the preparation and acceptance for publication and/or presentation of the results of some of the Program's state-of-the art country program and monitoring and evaluation work: The Program's white paper on integration, entitled "Responses to Neglected Tropical Disease Integration: Key Concepts from Country Experiences", was submitted to the NTD PLoS Journal; The Program submitted an abstract on its work in analyzing the validity of MDA coverage survey data to the American Society for Tropical Medicine and Hygiene (ASTMH). The abstract, entitled, "Testing validity of reported drug coverage rates of the neglected tropical disease control program in four countries" was accepted for a poster presentation at the December 2008 ASTMH Meeting; The Program presented at the April GAELF 5 Meeting in Arusha, Tanzania the preliminary results of its work, carried out in collaboration with the LF Support Center in Atlanta, to determine the impact of integrated approaches to NTD control on the resources available LF. The LF Support Center and the NTD Control Program submitted an abstract on this work to the ASTMH, which was accepted for a poster presentation at the December 2008 ASTMH Meeting; The Program contributed to the preparation of the NTD chapter of the USAID Child Survival Report to Congress for 2008, developing graphs of its results, drafting a success story and providing a number of photos taken of the Program's work. The NTD Control Program is honored that 3 of these photos will be featured in the report, two in the chapter on NTDs and one will at the beginning of the executive summary

In May, RTI sponsored an auxiliary session at the Global Health Council Meeting. This session, held May 27, 2008 and entitled “Community-Based Integrated Neglected Tropical Disease Control: Early Country Experiences”, featured a panel composed of presenters from the NTD Control Program as well as from a wide variety of organizations with which the NTD Control Program cooperates. The NTD Control Program received high marks for the session.

Advocacy and Resource Mobilization work in the second half of Year 2 was focused on the development of a comprehensive life-of-project advocacy and resource mobilization strategy and of a detailed plan for roll-out of this strategy in the Program’s third year. According to this strategy, the Program’s advocacy and resource mobilization efforts beginning in Year 3 and continuing through the life of the project, will focus on creating environments supportive of the development and implementation of country-level sustainability plans (SP) for NTD control and country exit strategies (ES) for the NTD Control Program itself. The development of SPs and ESs may provide the strategic framework for resolving the problem of donor resource diversification and compromised country commitments to NTD control. The development of these strategic frameworks will also offer national governments, international organizations, bilaterals, NGOs, and others the opportunity to engage better in long term planning and hopefully achieve longer-term assurance that sufficient resources from diverse sources will be available to attain disease elimination when and where possible and control during the high burden phase. These frameworks will also help to determine at what point to scale down control programs when elimination or sufficient control has been achieved. This process will allow for projecting the costs of control maintenance and surveillance. The adoption of SPs and ESs is a logical evolution of the NTD Control Program, which set the scaling up of drug treatment as a pressing priority at project start up; now as the Program has matured, its attention is increasingly turned to developing SPs and ESs.

## **2. Program Planning, Management, Monitoring and Evaluation, and Reporting**

During the second half of Year 2, the Program finalized and obtained approval for its Year 2 Work Plan and Budget, completed the initial draft of its Year 3 Work Plan and Budget, and filled two positions vacated by their incumbents. As in Year 1, the Program made a number of important contributions to the state-of-the-art in area of monitoring and evaluation, as is evidenced by the fact that its work will be featured in two presentations at the upcoming American Society of Tropical Medicine and Hygiene annual conference.

### **2.1 Program Management**

In the second half of Year 2, two Program positions – Senior Grants Manager and Documentation and Dissemination Assistant – were vacated. Both positions were re-

filled within approximately one month. Recruitment continues for a qualified candidate for the position of Advocacy and Resource Mobilization Specialist.

The Program's Year 2 staffing plan remained unchanged. Planning for an early November staff retreat, aimed at ensuring that staff roles and responsibilities are clearly delineated and well-understood, was carried out in the second half of Year 2.

## **2.2 Monitoring and Evaluation**

The focus of activities during Year 2 was to refine the M&E Plan to reflect lessons learned during the Program's first year. This included modifying data collection instruments to add indicators of additionality and integration and refining data collection and tracking tools used by grantees and the Program to generate data on progress toward Program goals.

## **2.3 Program Reporting**

### **Financial Reports**

RTI submitted financial reports in accordance with 22 CFR 226.52.

### **Annual Work Plan**

The Year 3 Work Plan was submitted September 9, 2008.

### **Semi-Annual Program Reports**

The Semi-Annual Program Report for the period October 1, 2007-March 30, 2008 was submitted May 2, 2008.

Additionally, the NTD Control Program Director, Deputy Director, and Senior Grants Manager briefed the USAID CTO and other relevant USAID staff on Program progress on a regular basis, and prepared bi-weekly or monthly NTD Control Program Updates for USAID to share with Missions in participating countries.

# **3. Direct Implementation of Integrated NTD Control**

## **3.1 Overview**

Implementation of integrated NTD programs in Year 2 took place in eight countries: Burkina Faso, Ghana, Mali, Niger, Uganda, Haiti, Southern Sudan and Sierra Leone. During the Program's work planning meeting in January the team jointly determined that due to the fact that the Program's new funding for Year 2 was limited to only a slight increase over funding for Year 1, while three new countries has been added, funding for

the first five country programs would remain constant. Thus, scale up for increased coverage resulted from budget efficiencies rather than increased funds.

The three new country programs selected (Haiti, Southern Sudan and Sierra Leone) faced serious challenges to implementation due to hurricanes, post-conflict settings, security concerns, weak government infrastructure and high cost of operating in these settings. Stakeholders meetings were held in Haiti and Sierra during the second quarter of Year 2, and in Southern Sudan the meeting was held in May 2008. MDA is being conducted in the first quarter of Year 3 in both Haiti and Sierra Leone, and integrated mapping is planned for the first half of Year 3 in Southern Sudan.

Highlights of Year 2 achievements are summarized below.. Note that at this time all data are preliminary and based on reported coverage information. Data will be updated and finalized following the conduct of post-MDA validation surveys.

### **3.2 Coverage**

During the second year of implementation the NTD Control Program successfully initiated mass drug administration campaigns in seven countries, and successfully completed the campaigns in four (Niger, Burkina Faso, Mali and Uganda). Three additional MDAs are taking place in Haiti, Ghana and Sierra Leone in the first quarter of Year 3, and will be completed before December 2008.

**In Year 2 the Program successfully delivered approximately 57 million treatments to over 27 million people in four countries** (Burkina Faso, Mali, Niger, and Uganda). During the first 2 years of the program over 90 million treatments were provided to 30 million people, over half of the NTD Control Program's life of project goal of 160 million treatments provided to 40 million people.

Also during Year 2, preparations for MDAs in three additional countries were undertaken. The MDAs in Haiti, Ghana and Sierra Leone will take place during the first quarter of Year 3, targeting approximately 10 million additional people, who will be counted in Year 3 reports.

During Year 2 country programs achieved coverage rates of over 80% of the population eligible for treatment as shown in Table 3.

**Table 1. Treatment Coverage Rates by Country and by Drug for Year 2**

<b>Treatment Package</b>	<b>Niger</b>	<b>Mali</b>	<b>Burkina</b>	<b>Uganda MDA 1</b>	<b>Uganda MDA 2</b>	<b>Total</b>
IVM + (ALB)	73	85	100	78	86	
IVM alone				82	93	
PZQ+ ALB	88			84	75	
PZQ alone	81	84	100	86	90	
ZITHRO+TÉTRA	73	76	79	57	97	
<b>Coverage Rate Average</b>	<b>79</b>	<b>82</b>	<b>93</b>	<b>77</b>	<b>88</b>	<b>84</b>

### **3.3 Additionality**

Despite the fact that only four of the eight countries completed MDAs during the Year 2 and the NTD Control Program received only a marginal increase in the overall level of funding, during its second year the Program made significant achievements in the following areas:

- Ø mapping of new geographic areas
- Ø number of people treated
- Ø number of treatments provided
- Ø number of implementation units (geographic) targeted for treatment

Summary statistics are presented in the tables below comparing the progress made in Years 1 and 2 of the Program.

**Number of people treated.** Table 4 shows the number of people treated using USAID funding only, and attributable to USAID, in Years 1 and 2 for each country program. The program increased the number of population treated by nearly 70%. The estimated total number of people treated in Years 1 and 2 is approximately 30 million, including the 27 million treated in Year 2, and the approximately 3 million treated for trachoma in Year 1, but not in Year 2.

**Table 2. Number of People Treated Year 1 and Year 2 by Country with USAID Funding** (does not include treatments funded by governments and other donors)

Country	Pop. Coverage (millions)	
	Year 1	Year 2
Burkina Faso	1.0	4.4
Ghana	5.3	0.0
Mali	4.6	9.1
Niger	5.3	6.3
Uganda	0	8.0
Haiti	0	0.0
Sierra Leone	0	0.0
S. Sudan	0	0.0
<b>TOTAL</b>	<b>16.2</b>	<b>27.8</b>

**Number of treatments provided.** Table 5 shows the number of treatments provided using USAID funding only, and attributable to USAID, in Years 1 and 2 for each country program. The number of treatments for Year 2 was 57.6 million, an increase from 36.7 million treatments in Year 1. The cumulative number of treatments for Year 1 and Year 2 is approximately 94 million.

**Table 3. Number of Treatments Provided by Year and by Country with USAID Funding** (does not include treatments funded by governments and other donors)

<b>Country</b>	<b>Treated Year 1</b>	<b>Treated Year 2</b>
Burkina Faso	2.5	7.9
Ghana	11.8	0.0
Haiti	0.0	0.0
Mali	11.3	17.6
Niger	11.9	14.8
S. Sudan	0.0	0.0
Sierra Leone	0.0	0.0
Uganda	0.0	17.3
<b>TOTAL</b>	<b>36.7</b>	<b>57.6</b>

**Number of districts targeted for treatment.** During Year 2 the total number of districts treated was 185, an increase from the total of 144 districts in Year 1. Note that in several countries redistricting continues to causes the total number of districts to change without any corresponding change in actual geographic coverage. Also, successful elimination (as in Ghana for trachoma) and PZQ holidays (as in Burkina Faso in Year 1) results in an appropriate reduction of the number of implementation units over time, and fluctuation that does not indicate diminished performance or rapid scale up. Going forward we anticipate modifying this indicator to reflect achievement of national scale, to better reflect achievement of Program success toward the goal of achieving national scale.

Table 6 shows the number of districts or other implementation units where MDAs took place using USAID funding only, and attributable to USAID, in Years 1 and 2 for each country program.

**Table 4. Numbers of Districts Treated Year 1 and Year 2 by Country, with USAID Funding** (does not include treatments funded by governments and other donors)

Country	District Coverage	
	Year 1	Year 2
Burkina Faso	3 (PZQ holiday)	38
Ghana	60	0
Mali	24	58
Niger	19	26
Uganda	38	63
Haiti	0	0
Sierra Leone	0	0
S. Sudan	0	0
<b>TOTAL</b>	<b>144</b>	<b>185</b>

**Drug Donations.** The Program supported the distribution of over \$590 million worth of donated drugs during Year 2. Albendazole was donated mainly by GSK with a small contribution from Catholic Relief Services in Burkina Faso; Ivermectin was donated by the Mectizan Donation Program; Praziquantel was donated by SCI with a small contribution from Catholic Relief Services in Burkina Faso; Zithromax was mainly donated by Pfizer with a small donation from Kalsaka to Burkina Faso; DEC was provided by the University of Notre Dame with funding from the Gates Foundation and IMA World Health.

In addition to collecting information on donated drugs, we worked with the country programs to collect more accurate information about the contribution of other donors and the commitment of governments as measured through financial resources in order to document the additionality that USAID's funding is achieving. For example, the Government of Burkina Faso has continued to provide funds for national MDA for LF; the resources provided by the NTD Control Program were used to improve coverage through IEC and community mobilization activities, and to treat schistosomiasis, trachoma and STH in 36 districts. In Mali, the government has four budget lines for NTD programs.

### 3.4 Capacity Building

During Year 2 NTD Control Program partners strengthened the capacity of country level counterparts by providing training to over 200,000 workers at central, regional and district levels, as shown in Table 7 below. In each country, grantees, supported by NTD Control Program staff, provided on-going assistance to strengthen the strategic planning and management skills of country program managers.

**Table 5. Number of Workers Trained at all Levels for MDA in Year 2, by Country**

Country	Number of Workers Trained
Burkina Faso	50,283
Ghana	21,416
Haiti	986
Mali	25,354
Niger	25,658
Sierra Leone	31,181
South Sudan	0
Uganda	56,175

<b>Total</b>	<b>211,053</b>
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Additionally, the Program provided technical assistance to support grantees and country counterparts in work plan development, survey protocol and mapping, post-MDA survey implementation and reporting, data analysis and data collection and reporting against Program indicators.

- In Mali the NTD technical staff assisted the LF national coordinator in preparing and reviewing the protocol for sentinel site surveillance. Support has been provided to country program staff to explore the possibility of using “the national week for intensification of nutrition activities” (SIAN) as platform for integration of NTD control activities. To pursue with the integration efforts, the co-implementation of MDA and SIAN will be field-tested in the region of Kayes in Year 3. Technical guidance was provided on an on-going basis to HKI and to national program managers in setting up an investigation of compliance and side adverse effects reported in the region of Kayes.
- In Burkina Faso daily technical support has been effective in moving program implementers from budgeting vertical (stand alone) trachoma MDA to reallocating resources for additional mapping.
- In Niger technical staff worked alongside SCI regional manager to undertake advocacy activities and to mobilize more partners to the NTD control program in Niger.
- The Program provided technical assistance to the Niger program for implementation of the post-MDA validation survey and data analysis.
- In Southern Sudan, Program technical staff provided significant technical assistance for program start-up, including development of a mapping strategy and protocol, assistance in establishing relationships with the drug donation programs and with critical partners such as the Carter Center, CBM and APOC.
- In Haiti, Program staff assured that the experience of other country programs in drug supply and procurement, social mobilization, and stakeholders’ involvement were available to the Haiti team. This assured improved planning and budgeting, emphasized MOH ownership of the program, strengthened coordination with partners, and helped secure the DEC donation Haiti required.
- In Ghana, technical assistance was provided by SCI and Program staff in implementation and data analysis of the schistosomiasis survey, yielding a preliminary map. Ghana is now undertaking its first nation-wide distribution of praziquantel targeting 2,264,000 school age children in 45 districts
- In Sierra Leone, Program staff provided training on blinding trachoma and on mapping of blinding trachoma to 12 senior members of the Sierra Leone NTD control program team.

### 3.5 Sustainability

During Year 2, the Program took many significant steps toward ensuring government ownership and leadership of their national NTD control programs. Building on the lessons learned by the Program in Year 1 and guided by the results of the global assessment of NTD programs conducted by WHO in the first quarter of Year 2, these steps included:

- In Uganda, RTI's offices in Kampala, were relocated to the MOH Vector Control Division (VCD) offices in Kampala to ensure closer collaboration and to maintain MOH ownership of the Program.
- New grantees were strongly encouraged to place their technical advisor/focal point in MOH offices where possible. In Mali, HKI's focal point sits in the MOH offices, and the computers and other equipment that had been purchased for the grantee, ITI, were transferred to the MOH. In Ghana, World Vision's focal point shares MOH office space with the NTD control program coordinator. In Haiti a joint office was established for the NTD control program, shared by the MOH, IMA, and the University of Notre Dame.
- In all NTD Control Program participating countries, the role of the grantees as being **supporters** rather than implementers of the national programs was emphasized during the reporting period, to assure strong government ownership of the country programs.
- Cost efficiency was particularly well-demonstrated in Mali, where significant scale-up took place during Year 2 with only a modest increase in resources. In Year 2 Mali reached over 8 million people, up from 4.6 million people in Year 1. This was primarily due to the commitment of the local disease-specific program managers and MOH leadership, and their efforts to find ways to maximize their reach and overcome the challenges of working as individual programs.

### 3.6 Integration

In Year 2, countries reported finding efficiencies of the following type in implementing integrated NTD control:

- Reduced time in planning meetings, supervision and evaluation meetings as several vertical programs now work under one NTD program
- Reduced printing costs due to the integration of posters, brochures, treatment announcements, radio and TV spots, and program documents and manuals.
- Reduced transport costs through integrated delivery of drugs and supplies.
- Reduced transport, per-diems and facilitator costs due to combined training of health workers and community volunteers.
- Reduced supervision costs as one supervisor can now supervises MDAs for various disease programs.

- Cost savings from the conduct of integrated coverage validation surveys.
- Reporting done once per year for all drugs.
- Reduced number of national and regional meetings for planning and for presenting and discussing results.

Country-specific achievements in demonstrating successful integration include the following:

- In Uganda, all of the disease-specific programs, except for the trachoma program, were already housed in the VCD office. During Year 2, the country program managers decided that it was important for the trachoma program to have office space at VCD to ensure closer collaboration and stronger integration.
- The Government of Burkina Faso has committed to support a single integrated laboratory for all NTDs. This translates into integration and cost efficiencies for the government of Burkina Faso. In addition, Burkina Faso has shown further support for integration by combining all vertical M&E teams into an integrated team to support NTD sentinel site surveillance. As disease-specific program managers have left their positions, the NTD control program has decided not to replace these positions in the organizational structure, but rather to move toward achieving a unified, integrated NTD control program with one manager.
- In Haiti, two separate disease-specific programs for LF treatment and STH treatment were merged for the first time under the partnership of the MOH with IMA World Health and University of Notre Dame. The establishment of the Consortium supporting the Haiti NTD program signifies the collaboration of Gates Foundation/University of Notre Dame-supported MDA activities and the USAID-funded IMA program in support of common strategies and protocols developed by the MOH.
- In Sierra Leone, the integrated NTD control program builds on the existing onchocerciasis control program, and has avoided establishing disease-specific program managers. Disease-specific mapping and technical oversight is provided by external technical advisors and assistance from the core partners, APOC, Sight Savers International and HKI. In addition, the management of NTDs is now being integrated into the Primary Health Care system of Sierra Leone, which may ensure sustainability of activities after USAID funding ceases.
- In Southern Sudan, to assure cost-efficiencies, an integrated mapping protocol has been developed, and MDA will be piggy-backed onto the existing MDA for onchocerciasis implemented by CBM.
- In Ghana, the completion of the schistosomiasis mapping activity will allow treatment for schistosomiasis to be integrated into the school-based de-worming program for the first time in the up-coming MDA.

### **3.7 Drug Procurement and Management**

A total of \$5.3 million of praziquantel and albendazole were procured by the NTD Control Program in Year 2; \$2.6 million for distribution in Year 2 and \$2.7 million for distribution in Year 3. Because there is a greater demand among country programs for praziquantel than the Program can currently satisfy, the drug allocations for Year 3 were determined by consensus at the Program's January 2008 partners' meeting.

To allow the Program to expand to include a number of countries in Asia, we submitted a request for a waiver to procure DEC and mebendazole, which was successfully obtained in October 2008.

### **3.8 Development of Tools for Integration**

During Year 2 we updated guidelines for conducting stakeholders' meetings, based on the experience of programs to date. In addition, we continued to refine the M&E reporting tools to streamline reporting on program indicators and drafted an M&E field manual for grantees and country program managers.

### **3.9 Operations Research to Improve Integrated Program Performance**

In Year 2, the Program initiated discussions on selected operations research of integrated NTD control program models, including the CDTI+ model being implemented in Sierra Leone in collaboration with APOC.

In addition, as country program work plans for Year 3 are developed, the NTD Control Program has identified as a priority the need to undertake operations research to document the essential post-elimination surveillance and monitoring systems for the NTDs, and particularly for LF. Discussions with key partners, including CDC, the Mectizan Donation Program, pharma partners, WHO, AFRO, and the LF support centers was initiated in the last quarter of Year 2 to develop consensus about how to move forward on this critical issue.

## **4. Grants Administration for Country Programs**

All anticipated grants administration benchmarks for Year 2 were achieved, with the exception of finalization of awards for Asia which could not happen due to circumstances beyond our control (delay in receipt of USAID Mission concurrence) and issuance of a global solicitation which has been moved to November 2008.

### **4.1 Issuance of Grants**

A Request for Application for new partners for the Neglected Tropical Disease (NTD) Control Program in Asia was released on June 16, 2008 for the following countries: Afghanistan, Bangladesh, Burma, Cambodia, East Timor, India, Indonesia, Lao (PDR), Nepal, Pakistan, Papua New Guinea, Philippines, Sri Lanka, Vietnam, and Yemen.

Six applications for programs in India, Nepal, Bangladesh, Cambodia, PDR Laos and Vietnam and Philippines were received by the deadline of July 31, 2008. A technical review panel composed of one representative of RTI, one from Imperial College, two from USAID and one from CDC was convened, and three applications were ranked as finalists. The technical review panel composed rigorous technical questions for each of the finalists for further clarification on the proposed implementation of the NTD Control Program, target population, role of the governments and management of the program. The three finalists submitted detailed responses to the technical review panel questions.

After the technical review panel convened a second time to evaluate responses, the British Leprosy Relief Association (LEPRA) was selected as the new USAID NTD grant partner to coordinate and monitor the distribution of medicines in Bangladesh and Nepal. This will be facilitated by two separate grants to LEPRA.

#### **4.2 Grants Management Support and Partnership Building**

Daily and weekly support to grant partners is provided across numerous areas by the NTD Control Program team: managing US government funds, integrating neglected tropical diseases, mapping and MDA implementation, supporting governments as owners of the process including providing funds and achieving additionality. Grants management under the NTD Control Program emphasizes partnership building through a social process of building mutual trust, common goals and a sense of one team working together to overcome challenges, find innovations, define sustainable exit strategies that include leveraging resources and reducing costs. During this reporting period, assistance was provided to partners and in-country teams, including -

- Mali – Helen Keller International.
- Sierra Leone – Helen Keller International.
- Burkina Faso – SCI Imperial College.
- Niger – SCI Imperial College.
- Southern Sudan – Malaria Consortium.
- Haiti – IMA World Health.
- Uganda – RTI International.
- Ghana – World Vision.

### **5. Technical Advisory Group**

In Year 2, based on its highly successful experience with its Praziquantel Meeting in Year 1, the NTD Control Program articulated a strategy for its TAG that takes full advantage of the Program's participation in existing global advisory bodies and minimizes duplication of efforts with these bodies. In Year 2, therefore, the Program participated as an observer in the important global advisory body, the WHO Strategic and Technical Advisory Group (STAG) on NTDs. The NTD Control Program Director also participated in the Gates Foundation NTD Stakeholders' Meeting, held in Seattle, June 11-12.

At USAID's request, rather than organizing the mini-TAG meetings originally planned for the second half of Year 2, the Program focused its efforts on actively supporting USAID and WHO as they prepared for the Meeting of the Stakeholders in the Presidential NTD Initiative. In addition to assisting with meeting logistics, including sponsoring 20 participants from developing countries around the world, the NTD Control Program contributed extensively to the development of the 4 working papers prepared for discussion at the Meeting. In particular, the Program made major contributions to the Working Paper on Monitoring and Evaluation, authored by WHO, co-sponsored with CDC the early September meeting held in Atlanta to further develop the CDC-authored Working Paper on Operational Research, and commented extensively on the Working Paper on Country Selection authored by USAID.

## **6. Documentation and Dissemination of Program Lessons**

The Program's major efforts in the area of documentation and dissemination of Program lessons learned in the second half of Year 2 were the preparation for publication and/or presentation of the results of some of the Program's state-of-the art country program and monitoring and evaluation work, detailed below, and the development of a comprehensive Documentation and Dissemination plan for inclusion in the Program's Year 3 Work Plan.

In May, RTI sponsored an auxiliary session at the Global Health Council Meeting. This session, held May 27, 2008 and entitled "Community-Based Integrated Neglected Tropical Disease Control: Early Country Experiences", featured a panel composed of presenters from the NTD Control Program as well as from a wide variety of organizations with which the NTD Control Program cooperates:

- CDC (Els Mathieu): Togo country program experience
- GNNTDC (Peter Hotez): GNNTDC experience in Latin America
- ITI (Sam Abbenyi): ITI experience in Morocco
- MDP (Adrian Hopkins): CBM experience in Southern Sudan and DRC
- NTD Control Program (Johnny Gyapong): Ghana Country Experience
- SCI (Alan Fenwick): SCI experience in Burundi.

The NTD Control Program received high marks for the session, as indicated in one comment below:

*Congratulations on having put on such a great symposium the other day! It was the best NTD symposium I have yet seen. The focus on the countries was excellent, and the diversity of presentations gave the audience a great overview, including for the Americas*

*which usually gets no attention. The other thing that made the symposium so valuable, I believe, was the balance between start-up labor pains and ultimate successful deliveries. It is important for people to see just how difficult something like you are trying to do really is. It's amazing how well it is going now and how much the NTDCP [NTD Control Program] is appreciated by the once-skeptical community!*

## **7. Advocacy and Resource Mobilization**

The major focus of the NTD Control Program's advocacy and resource mobilization work in the second half of Year 2 was the development, for inclusion in the Year 3 Work Plan, of a comprehensive life-of-project advocacy and resource mobilization strategy and of a detailed plan for roll-out of this strategy in the Program's third year. The strategy and Year 3 plan have recently been reviewed by USAID as part of its review of the Program's Year 3 Work Plan. In general, USAID is supportive of the strategy, briefly described below, but has requested more details on the actual activities to be carried out in Year 3.

The NTD Control Program's advocacy and resource mobilization efforts beginning in Year 3 and continuing through the life of the project, will focus on creating environments supportive of the development and implementation of country-level sustainability plans (SP) for NTD control and country exit strategies (ES) for the NTD Control Program itself.

Achieving greater resource diversification with both a SP and an ES strategic framework requires that the NTD Control Program engage in much more extensive and intensive advocacy. The work plan for Year 3 focuses on those areas where advocacy and allied communication activities have most to offer and where advocacy strategies can be most effectively concentrated to help address the basic challenges of sustaining NTD control through a diversification of funding commitments including that of affected countries through the adoption of budget line items for NTD control.

This advocacy, communication and resource mobilization plan will first be introduced in two countries, likely one of the original "fast-track" countries and, perhaps, one of the two countries, Bangladesh and Nepal, added to the Program at the end of Year 2.

## **8. Activities Planned for the Next Six Months**

### **Program Planning, Management, Monitoring and Evaluation, and Reporting**

- Recruit Advocacy and Resource Mobilization Specialist
- Finalize report of Year 2 performance results.
- Provide training in and test use of new database tools in Ghana and Mali

- Continue to work with WHO to develop new international integrated monitoring and evaluation guidelines for NTD control.
- Finalize cost study in Haiti.
- Expand analysis of impact of integration on disease-specific resources to include onchocerciasis.
- Initiate development of new approaches for assessing program impact, including strategy for measuring the impact of NTD control on the Millennium Development Goals.

### **Direct implementation**

- Provide technical assistance as needed to Burkina Faso, Ghana, Haiti, South Sudan and Sierra Leone country programs for finalizing Year 3 work plans and budgets.
- Support mapping in Uganda, Sierra Leone, and Southern Sudan.
- Provide technical and management support for training and MDA preparation in Burkina Faso, Niger, and Uganda.
- Support MDA implementation in Burkina Faso, Mali, Niger, Sierra Leone, Southern Sudan, and Uganda.
- Provide technical support for MDA coverage surveys in Burkina Faso, Ghana, Haiti, Niger, Sierra Leone, and Uganda.
- Procure and assure timely delivery of PZQ and ALB for Year 4 and provide technical support for preparation of applications for donated drugs

### **Grants Management**

- Conduct monitoring and training site visit to Niger and Burkina Faso
- Finalize Year Three Work plan and Budget for Burkina Faso
- Draft APS to USAID and post APS
- Conduct start-up workshop in DC with LEPRAs- Finalize Letter of Authorization to begin work
- Finalize LEPRAs Nepal and Bangladesh Year 3 Work Plans and Budgets
- Finalize HKI Sierra Leone Year 3 Work Plan and Budget
- Finalize World Vision Ghana Year 3 Work Plan and Budget after December stakeholders meeting
- Finalize IMA World Health Haiti Year 3 Work Plan and Budget post-MDA
- Conduct monitoring and site visit to Southern Sudan and finalize Malaria Consortium Southern Sudan Year 3 Work Plan and Budget
- Receive and review APS applications
- Convene APS Technical Review Committee and rank applications

## **TAG**

- Provide support for organization of and participate in Presidential NTD Initiative Stakeholders' Meeting and follow-up efforts
- Hold mini-TAG meeting on sustainability planning and development of exit strategies.
- Hold mini-TAG meeting on developing guidelines for PZQ holidays.

## **Document Dissemination**

- Populate NTD Control Program web site
- Re-design NTD Control Program web site
- Produce quarterly NTD Control Program newsletter
- Develop NTD Control Program standard presentation
- Present NTD Control Program experience, results, and lessons learned in relevant forums

## **Advocacy & Resource Mobilization**

- Develop justification for necessity of Exit Strategy (ES) and Sustainability Plan (SP); incorporate in NTD Control Program Advocacy and Resource Mobilization PowerPoint presentation.
- Develop evidence of pre-and post-NTD Control Program levels and diversity of donor support for NTD control.
- Establish measures for evaluating country-level support (private and public) for NTD Control Program integrated control.
- Create generic blueprint of advocacy, communication, and social mobilization (ACSM) steps and activities likely to be required for implementing SP and ES.
- Develop M&E benchmarks to use as measurements in the formulation of SP and ES.
- Develop advocacy enhanced training modules for community distributors.
- Select two countries (existing country and new country) to develop SP and ES and to implement the supportive ACSM strategies; build SP, ES and ACSM into work plans of grantees for these countries.
- In selected countries, conduct rapid advocacy and resource mobilization assessments
- Develop/adapt existing supports for in-country ACSM, messaging, and media workshops.