Section 3
Terms of Reference (Revised Sept 2017)

Terms of Reference for Integrated Programme Approach to Control a range of Neglected Tropical Diseases (NTDs) in Nigeria

Introduction

The UK will provide funding up to March 2019 to implement an integrated programme in Nigeria among five states (Kaduna, Kano, Katsina, Niger, Zamfara) to control seven Neglected Tropical Diseases (NTDs) (blinding trachoma, schistosomiasis, Lymphatic filariasis, river blindness, hookworm, whipworm and roundworm). By 2016, this programme will reach 26 million people with annual mass drug administration (MDA) (prophylactic drug therapy to everyone in a community) to reduce illness and will have distributed over 110 million treatments.

DFID will work with USAID, other development organisations, and the Nigerian authorities.

The targeted Neglected Tropical Diseases (NTDs) are preventable with proven, cost effective interventions, such as MDA, which, depending on the prevalence of diseases, involves distributing up to four drugs once or twice a year to prevent the seven diseases. These drugs are donated, in whole or in part, by pharmaceutical companies, and distributed by community volunteers. At start up, MDA has been estimated to cost less than $0.50 to treat one person for a year, with the resulting cost effectiveness of less than $10 per disability adjusted life year (DALY) averted.

As many of the NTDs are tackled using similar community and school mechanisms, an integrated approach can be used, in which drugs for different diseases are administered at the same time. This is cost effective as many areas are burdened with more than one of the NTDs. It also gives the opportunity for a more sustainable approach to tackling NTDs using existing community and school-based structures and enabling Nigeria to tackle the diseases that affect its population.

The UK is a key player in the control and prevention of NTDs, alongside the World Health Organization (WHO), USAID and the Bill and Melinda Gates Foundation. In 2011 ministers scaled up DFID's involvement in NTDs with additional funding of £195 million over 2011-15, and announced this formally at the 'London Declaration on NTDs' in January 2012. The event marked the launch of an expanded, coordinated effort against NTDs by the end of the decade, with a strong collaboration between donors, pharmaceutical companies, academics, foundations, international financial institutions and countries afflicted by NTDs. One of the initiatives announced by the UK at this event was an integrated programme approach to tackle NTDs in two countries. The UK made a further commitment in April 2017, announcing a £360m investment on implementation programmes to tackle NTDs between 2017-2018 and 2021-22.

Section 3
Terms of Reference (Revised Sept 2017)

Objective

The objective of this requirement is to implement an integrated programme, on behalf of the recipients and beneficiaries of the service, in Nigeria to control seven NTDs (blinding trachoma, schistosomiasis, lymphatic filariasis, river blindness, hookworm, whipworm and roundworm).

The core roles of the contracted Supplier will be to manage the programme to deliver results, secure value for money in the use of programme resources and ensure measurement of programme results. The tender will allow more than one organisation to be part of a bid, as long as there is one clear lead organisation that will be responsible for the contract and accountable to DFID and the NTD Steering Committee for all activities and results. The NTD Steering Committee was established by the Federal Ministry of Health to provide technical guidance and review progress towards NTD elimination in the country. Best practice from the UNITED programme is shared with the steering committee for adoption and roll out across the country, including standardised processes in drug supply chain management.

Recipient

The recipients of the Services are the Nigerian State and Federal Ministries of Health. The Supplier will be accountable for the programme to both DFID and the Federal Ministry of Health (FMOH). The Supplier will be responsible for working closely with the Nigerian Federal Ministry of Health and with the targeted State Ministries of Health.

The Supplier will be contracted by DFID, who will procure and pay for these services to be delivered for the benefits of the Nigerian Federal Ministry of Health and the targeted State Ministries of Health. The supplier will report directly on financial and programmatic information to DFID but key outputs will also be shared with the Ministries of Health.

Scope

The programme aims to deliver an effective, integrated, efficient and evidence based approach to integrated NTD control in Nigeria from 2013-2019. The programme will comprise key areas of activity and cross cutting themes:

The key areas of activity will be:

- **Mapping** - Mapping of NTDs is necessary to enable targeting of resources to areas most in need and provide the information required for medicine donations to be established. Most mapping needs were completed in year 1.
- **Mass drug administration (MDA)** - this includes annual community distribution of Ivermectin and Albendazole for LF, annual community distribution of Ivermectin for River Blindness, annual community distribution of Zithromax for blinding trachoma, annual or once per two year treatment of Praziquantel for schistosomiasis, and annual or semi-

annual treatment of Albendazole or Mebendazole for hookworm, whipworm and roundworm).

- **Communication and coordination** - It is important to promote behavioural practices that will protect people from the diseases and help people understand the reasons for mass drug administration. It is important to ensure communication is on-going with other relevant programmes (health, education, WASH) to exploit synergies and maximise efficiency.
- **Drug supply chain management** - The State Ministries of Health require support at the Federal level for clearance of donated drugs, and drug management. The programme will ensure that drugs are appropriately stored and transported to areas they are distributed. **Health systems strengthening** - It is important the State Ministries of Health help tackle the diseases that affect its population, to maximise sustainability of this programme.
- **Impact assessments and post-MDA surveillance:** Following the necessary rounds of MDA, endemic LGAs will conduct impact assessments to determine if treatments can be stopped before transitioning to a post-MDA surveillance period (duration varies depending on disease) during which time periodic surveys are conducted to detect any reinfection of disease. These surveys are important to either validate elimination of disease as a public health problem or (schistosomiasis, hookworm, whipworm and roundworm) or verify elimination of disease transmission (LF, River Blindness, blinding trachoma).
- **Planning for responsible exit from programme activities at the end of the contract period** – This will include consideration of options for continuation of required treatment and surveillance activities, where possible, favouring options that transfer oversight to adequately prepared Federal and State Ministries of Health.
- **Clearance and procurement** - In addition, during the extension period from 1st October 2017 up to 31 March 2019, the Supplier will be responsible for clearance of medicines and procurement of goods and equipment for the programme, within the allocated additional budget envelope of £3,180,000.

<u>The cross cutting themes are:</u>

- **Sustainability** – to maximise the sustainability of the programme, to ensure that activities can be maintained if external funding is no longer available.
- **Resilience/adaptation to potential fragility** - There are many challenges in delivering programmes in Nigeria. Therefore any programme needs to be sufficiently resilient to the challenges that arise.
- **Evidence for decision making** - Monitoring of the programme is necessary to measure results, and to feed into the national and global NTD picture. Evaluation is important in order to identify areas of the

programme that need adapting, and learning lessons from challenges for future programmes.

- **Security** – Continuous monitoring of the security status and adapting security arrangements within the programme remain one of the key priority area for the successful delivery of the programme.

The **impact** of the programme will be a continued reduction of the disability, disfigurement, stigma, lost livelihoods and poverty, and their social and economic costs, which occur as a result of NTDs in Nigeria.

The **outcome** of UK support will be to reduce the prevalence of NTDs in Nigeria, and to establish sustainable integrated NTD programmes in targeted areas of the country.

The outputs of the programme will be:

- 112 million treatments[1] distributed over 4 years
- 26 million people will be reached with mass drug administration in 2016.
- 114,900 Disability Adjusted Life Years saved over 4 years (estimated).
- 30.3 million treatments administered through mass drug administration over the extension period October 2017 - March 2019[2].

The requirements

The Supplier is required to:

Within the **inception period** (first 3 months)

- Create an implementation plan for all aspects of the programme, following regular meetings between the supplier and FMOH, State MoH, USAID's implementing partners and DFID
- Design and plan the pilots for baseline and surveys in at least one Local Government Authority (LGA) area in each targeted state, to determine changes in disease prevalence as a result of the programme. It will be necessary to consult with epidemiologists during this period with regards to sample size and number of sites necessary.

The outputs to be completed over the **lifetime of the project** are**:**

- **Mapping**
    - Depending on the progress of the NTD mapping by USAID, the Children's Investment Fund Foundation and the DFID trachoma mapping consortium, the Supplier may be required to cover some NTD mapping gaps should they arise.

[1] One treatment is counted each time an individual receives one drug to treat one disease (counting only one treatment even if a single drug treats multiple diseases). Therefore if a person receives 3 drugs for 3 diseases over 4 years, this will count as 12 treatments

[2] Subject to the successful approval of the FMOH drug requests submitted in 2017.

- **Mass drug administration**
  - Integrated mass drug administration established in at least three targeted states in Nigeria by 2015. The prioritisation of states has been made based on NTD burden of disease, FMOH priority and DFID focus states. The choice of targeted states for implementation of MDA with DFID funding is a minimum of:
    - 2013: Commence integrated MDA in Zamfara state
    - 2014: Commence integrated MDA in Katsina state.
    - 2015: Commence integrated MDA in Kano, Niger and Kaduna states.
  - By 2016, the integrated mass drug administration programme should be reaching 26 million people, including 75% of the targeted population.
  - The programme should have distributed 112 million treatments[3] over the four years of the programme.
  - 30.3 million additional treatments will be administered through mass drug administration over the extension period October 2017-March 2019.

- **Communication and coordination**
  - Create and implement a behaviour change communication (BCC) and information education communication (IEC) plan for the targeted states (see MDA) in Nigeria, targeting acceptance of MDA as well as key behaviours, with a target of 13,800,000 people reached with BCC / IEC for NTD messaging. Regular (bi-annual) meetings to have taken place with WASH and education sectors, particularly in the targeted states (see MDA) to ensure co-ordination between the NTD programme and these sectors.
  - Discussions to have taken place with those implementing other relevant DFID funded programmes in the targeted states, including health systems strengthening, malaria, health service delivery, girls education and WASH.

- **Drug supply chain and procurement management**
  - Storage, transportation and supply chain management of the donated drugs in Nigeria from the FMOH Warehouse to the targeted states (see MDA) and onto the communities.
  - During the extension period from 1 October 2017 up till 31 March 2019, the supplier will manage all procurement activities including clearance of donated drugs as well as sourcing, monitoring and administrating payments related to procurement of goods and equipment. This will require monitoring and tracking of value for money across all procurement activities and robust due diligence of all downstream activity. In addition, the

[3] One treatment is counted each time an individual receives one drug to treat one disease (counting only one treatment even if a single drug treats multiple diseases). Therefore if a person is receives 3 drugs for 3 diseases over 4 years, this will count as 12 treatments

Supplier will be required to collaborate closely with the British High Commission for effective co-ordination of drugs clearance.

- **Health systems strengthening**
  - Maintain technical assistance to the FMOH in drug supply chain management. During the first three years, standardised processes and protocols for drugs applications, clearance, storage and transportation of donated drugs for mass drug administration was established in the five states. Private sector expertise was sought to support State and FMOH to enhance accountability of donated drugs, improve quality of reporting, and ensure timely drug requests are submitted. Co-ordination among the various implementing partners and States on use and expansion of these standardized protocols will continue during the extension period.
  - Provide technical assistance to the FMOH (together with USAID contracted organisation) to support coordination, strategy and policy development of the NTD activities including development of NTD annual plans and budgets by FMoH.
  - Provide technical assistance and support to the State Ministry of Health (SMoH) in targeted states (see MDA) in implementing the integrated NTD programme and Local Government Authorities, undertaking lead responsibility for delivery of the integrated NTD programme for the duration of the programme, or until FMOH has the capacity and capability to deliver without additional support. This technical assistance will include ensuring that annual plans/budgets are produced by State MoH and LGA as required.
  - Provide a capacity building plan to enable FMOH to be able to deliver full health systems planning, management and delivery by the end of the contract, with implementation of the capacity building plan.

- **Evidence for decision making**
  - Impact assessments will be undertaken in trachoma endemic LGAs to determine if treatments can be stopped. Data generated from the impact survey will support LGAs to scale-down treatments and move into a post-MDA surveillance period before submission of dossiers to WHO to validate elimination of trachoma as a public health problem.
  - Likewise, monitoring of sentinel sites will take place in schistosomiasis/STH endemic LGAs to determine if there has been a reduction in intensity of infection. Data generated from these exercises will support LGAs to scale-down treatments and potentially move into a post-MDA surveillance period provided that key indicators on water and sanitation are met.
  - Propose and implement mechanisms to ensure that State level reporting is aligned with Monitoring and Evaluation (M&E) mechanisms established at the Federal level.

- Contract an external evaluation to be conducted mid-way through the programme to identify areas for improvement, and at the end of the programme to learn lessons for future programmes. DFID and the Supplier to agree the scope and objectives for the evaluation by end of May 2018, to allow sufficient time for contracting out and completing the evaluation before the end of the contract. This evaluation will draw on the data collected and results measurement to draw conclusions on the impact; contributions to evidence and capacity building; and value for money achieved.

- **Close-out of the programme**
  - Close out of the programmatic activities will be conducted based on a clear exit/handover (depending on circumstances) strategy. The Supplier will be required to maintain an updated draft exit/handover strategy throughout the course of programme, and must agree with DFID a preferred option 6 months before the programme end date. Following this, a final Exit Plan will be agreed with DFID two months before the project end date. This will set out obligations in detail in order to ensure a smooth and efficient transfer of the Services.
  - Within reason, at any time during the extension period and as part of the Exit Plan, the Supplier will be required to provide within 21 days of being so requested by DFID or DFID's Representative the updated and accessible information related to the programme.
  - Within the first month the supplier is required to review with DFID the existing indicators relating to sustainability of the programme results and revise if required.

Constraints and dependencies

The Supplier must work alongside and ensure that all planning is done with the Federal and State Ministries of Health in Nigeria.

It is important to ensure a close working relationship with the organisation(s) contracted by USAID to deliver the integrated NTD programme in Nigeria, particularly in the provision of technical assistance to the FMOH.

The Supplier should remain in close communication with the Crown Agents contracted by DFID to clear the donated NTD medicines coming into Nigeria, as well as the pharmaceutical donor organisations that are sending these medicines.

It is important to work in collaboration with the other organisations working on NTDs in Nigeria, particularly those organisations within the current NTD steering committee, including WHO and UNICEF.

If DFID funds operational research on an integrated approach to NTDs in Nigeria, it will be necessary for the Supplier to work closely with the research Supplier, providing information as necessary, and using the findings of the research to improve implementation of the programme.

Implementation requirements

There will be a three month inception period. There will be regular meetings between DFID and the Supplier in the three month inception period to discuss plans for implementation of the programme. This includes monthly updates during this period. A meeting between DFID, the Supplier and the FMOH should take place during the inception period to discuss the plans, priorities and purpose of the designed programme.

The Supplier will be responsible for working very closely with the Nigerian FMOH and with the targeted State Ministries of Health in planning the programme during the inception period and afterwards. This will include how the activities will be carried out, funding arrangements and any additional partners for the programme activities.

There are opportunities for changes to be made to the design and plans of the programme. The key times for this are at the end of the inception period, following the mid-term evaluation and during annual reviews. However the programmes should be sufficiently flexible to enable adaptations to be made, in consultation with DFID/FMOH, in response to changes in the political or security context.

Duty of Care

The Supplier is responsible for the safety and well-being of their Personnel and Third Parties affected by their activities under this Contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property.

DFID will share available information with the Supplier on security status and developments in-country where appropriate.

The Supplier is responsible for ensuring appropriate safety and security briefings for all of their Personnel working under this Contract and ensuring that their Personnel register and receive briefing as outlined above. Travel advice is also available on the Foreign and Commonwealth Office (FCO) website and the Supplier must ensure that they (and their Personnel) are up to date with the latest position.

This requirement may require the Supplier to operate in conflict-affected areas and parts of it are highly insecure. The security situation is volatile and subject to change at short notice. The Supplier should be comfortable working in such

an environment and should be capable of deploying to any areas required within the region in order to deliver the Contract.

The Supplier is responsible for ensuring that appropriate arrangements, processes and procedures are in place for their Personnel, taking into account the environment they will be working in and the level of risk involved in delivery of the Contract (such as working in dangerous, fragile and hostile environments etc.). The Supplier must ensure their Personnel receive the required level of training and safety in the field training prior to deployment.

Tenderers must develop their PQQ Response and Tender (if Invited to Tender) on the basis of being fully responsible for Duty of Care in line with the details provided above and the initial risk assessment matrix prepared by DFID (see Annex A of this ToR). They must confirm in their PQQ Response that:

- They fully accept responsibility for Security and Duty of Care.
- They have made a full assessment of security requirements.
- They have the capability to provide security and Duty of Care for the duration of the contract.

If you are unwilling or unable to accept responsibility for Security and Duty of Care as detailed above, your PQQ will be viewed as non-compliant and excluded from further evaluation.

Acceptance of responsibility must be supported with evidence of Duty of Care capability and DFID reserves the right to clarify any aspect of this evidence. In providing evidence, interested Suppliers should respond in line with the Duty of Care section in Form E of the Pre-Qualification Questionnaire (PQQ).

Reporting

The Supplier will report to DFID Health Services Team. The reporting will include financial reports, programme reports and evaluations.

Financial reporting

Forecasts of spend will be reported on a monthly basis, including monthly comparison of budget with expenditure. The monthly financial reports will include justification for any variances and identified risks to spend and mitigating actions they propose to take. The monthly reporting will be supported by an updated costed workplan to reconcile with monthly invoicing.

Financial narrative reports will have to be produced on a 6-monthly basis.

Audited accounts will need to be produced on an annual basis together with a 6-monthly progress report (see below).

Section 3
Terms of Reference (Revised Sept 2017)

Programme reporting

Performance monitoring against programme outputs and outcomes in the logframe will be done through an informal written report produced six monthly in the first year, and annually from the second year onwards.

During the extension period from 1 October 2017 up to 31 March 2019, progress against outputs and outcomes will be monitored by DFID on a 6-monthly basis. As part of this process, the Supplier will be expected to submit a short informal narrative report (max. 5 pages) updating on the key activities undertaken, challenges and lessons learned, compliance, supply chain and risk assessment. The report should be supplemented by an update to the costed workplans. In addition, a regular quarterly update meetings will be held between the Supplier and DFID with the meetings clearly minuted and documented. These may include standing agenda items as well as ad hock topics.

A Project Completion Report will be produced one month before the end of the programme. The content of the report will be agreed between DFID and the Supplier in due course.

The Supplier is also expected to report to DFID at its earliest convenience any major constraints, risks and compliance issues identified at any point during the implementation and propose action taken to adapt/improve the programme to mitigate/manage these.

Evaluations

Evaluations should be initially planned at the end of the inception period, in discussion with DFID. There will be a mid-term review after the second full year of implementation (including an independent evaluation organised by the Supplier) that will consider whether the programme is on track or whether it requires revision, due to issues faced in implementation or to external changes such as political or security changes, or changes in NTD drug policy. An independent evaluation will also be done at the end of the programme, in order to assess the results and make recommendations on follow-up. This evaluation will draw on the data collected and results measurement to draw conclusions on the impact; contributions to evidence and capacity building; and value for money achieved.

Timeframe

The Contract will be let for four years. There will be Break Points in the Programme where the Supplier will require formal approval from DFID before starting work on the next stage.

- Break Point 1 – at the end of the 3 month inception phase.
- Break Point 2 – at the end of the first year of the programme.
- Break Point 3 – at the end of the second year of the programme.

Section 3
Terms of Reference (Revised Sept 2017)

Movement from one stage to the next will be dependent on DFID's acceptance of the design of the programme within the inception period, satisfactory performance and progress of the Supplier against the outputs specified in the agreed workplan and adequate political and security context for continued implementation of the programme.

An extension of the programme will be for 18 months form 1 October 2017 to 31 March 2019.

Key activities	**Phase 1 & 2: Y1**	**Phase 3: Y2**	**Phase 3: Y3**	**Phase 4: Y4**	**Phase 5: Y5**
Mapping					
Programme detailed planning					
Setting up of PMO					
Drug supply to the Sates					
Baselines (KAP, epi)					
Preparatory activities to MDA (training, tools production, etc.)					
Mass Drug Administration					
Behaviour Change Communication					
Health Systems Strengthening					
Mid Term Review					
Existing sustainability indicators reviewed and agreed					
Handover/Exit strategy developed					
End of project evaluation					
Reporting					

Section 3
Terms of Reference (Revised Sept 2017)

Reading key

	Gov. & Consortium
	Government leading
	Consortium leading

DFID coordination

The Supplier will report to a Health Adviser in the Health Services Team of DFID's Human Development Department. A Health Adviser will be responsible for all technical and policy aspects of the programme and have overall responsibility. A Project Manager in the same team will be responsible for the financial management and administration of the programme.

DFID reserves the right to change the reporting lines for this contract. Any change to the management of the contract will be notified to the Supplier in advance of any change.

Background

NTDs represent the most common diseases for the 2.7 billion people living on less than US$2 per day.[4] The infections cause loss of livelihood, disfigurement, stigma, disability and poverty. These diseases can lead to irreversible blindness, chronic illness, physical deformities and death (there are half a million deaths every year worldwide from NTDs). The term NTDs is used by WHO for 17 parasitic and bacterial infections with different distribution, epidemiology, transmission, vector involvement, aspects of diseases transmitted from animals, pathology, and requirements for prevention and control. This Contract will focus on seven of these NTDs:

- blinding trachoma
- schistosomiasis / bilharzia
- lymphatic filariasis
- onchocerciasis / river blindness
- soil transmitted helminths (STH) – hookworm, ascariasis / roundworm & trichuriasis / whipworm

At any one time as many as 500 million people in Africa (and over 1 billion globally) are infected with, or at risk of one or more NTDs[5], causing 534,000 deaths and the loss of approximately 57 million disability adjusted life years[6] (DALYs) annually. There is concern that DALYs underestimate the true

[4]Liese, Rosenberg and Schratz (2010) Programmes, partnerships and governance for elimination and control of neglected tropical diseases. *The Lancet*; 375: 67-76.
[5]Hotez P, Stoever K, Fenwick A, Molyneux D, Savioli L.2006 *Lancet.* 367. 563–564
[6] The DALY is a common indicator of the burden of disease in a population – the sum of DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation. The DALY can be thought of as one lost year of healthy life due to disease or injury.

suffering associated with NTDs[7]. NTDs affect the poorest, hardest to reach people, who are often in remote or conflict zones, with minimal access to health services, and contribute to perpetuating conditions of poverty[8,9]. There is also evidence of inequities in the distribution of the burden of disease of some NTDs, with women and children disproportionately affected. For example, adult women represent 70% of the trichiasis burden and are more than twice as likely to be afflicted in comparison to men[10], whilst schistosomiasis and soil transmitted helminths (STH) primarily afflict children.

Nigeria has the greatest number of people living with NTD infections in Africa. All of the targeted NTDs are endemic over large areas of the country. It is estimated that over 100 million persons (two out of every three Nigerians) suffer or are at risk from one or more of these diseases. All 774 LGAs in the 36 States, as well as the Federal Capital Territory (FCT) are endemic for one or more of these NTDs[11].

The growing body of evidence demonstrates that control of NTDs will significantly reduce illness, social exclusion and mortality[12]. Intensified control of NTDs improves productivity, maternal and child health, increases access to education and addresses gender and other inequities that underpin slow progress towards the achievement of the Millennium Development Goals (MDGs).

The seven targeted NTDs (ascariasis, hookworm infections, lymphatic filariasis, onchocerciasis, schistosomiasis, trichuriasis, and trachoma) are preventable by a simple oral drug treatment administered once or twice a year, with four drugs: albendazole/mebendazole, ivermectin, praziquantel, and azithromycin[13]. This is described as “Preventative Chemotherapy (PCT)”. All of these drugs are currently donated in whole or in part by pharmaceutical companies. Prior to 2000, there were only a few programmes targeting individual NTDs in sub-Saharan Africa, which were usually supported by international organisations or partnerships[14]. These programmes include the African Programme for Onchocerciasis Control (APOC), Global Alliance to

[7] Engels E, Savioli L. 2006. Reconsidering the underestimated burden caused by neglected tropical diseases. *Trends Parasitol.*22 363-366
[8]HotezPJ, Ottesen E, Fenwick A, MolyneuxD.The neglected tropical diseases: the ancient afflictions of stigma and poverty and the
prospects for their control and elimination.*AdvExp Med Biol*
[9]HotezPJ, Fenwick A, Savioli L, Molyneux D. 2009.Rescuing the bottom billion through control of neglected tropical diseases.*Lancet.*373:9674 1570-1575
[10] Women and Trachoma (2009) The Carter Centre and Kilimanjaro Centre for Community Ophthalmology.
[11]Powerpoint presentation: NTDs control in Nigeria, FMOH
[12]Canning D. 2006.Priority setting and the “neglected” tropical diseases.*RoySoc of Tro Med Hyg*100 499-504
[13]Fenwick A, Molyneux D, Nantulya V. Achieving the Millennium Development Goals. *Lancet* 2005;**365**(9464):1029—30.
[14]Fenwick A, Control of the Neglected Tropical Diseases in sub-Saharan Africa: the unmet needs

Eliminate Lymphatic Filariasis (GAELF), Schistosomiasis Control Initiative (SCI) and International Trachoma Initiative (ITI).

There are a number of components that include or facilitate the integrated MDA programme:

- **Mapping:** There is an urgent need to complete the mapping of NTDs in Nigeria, as this will enable targeting of resources to areas most in need, and provide the information required for medicine donations to be established. Completing mapping would also highlight the NTD needs and make it easier for other donors to establish NTD programmes in Nigeria. It is likely that mapping will be completed by USAID, CIFF and the DFID funded trachoma mapping consortium. However if there are mapping gaps remaining these will need to be filled.
- **Mass Drug Administration:** Integrated MDA activities will build on the existing onchocerciasis distribution platform where this exists in selected states, or establishing new distribution platforms where onchocerciasis programmes are not present.
- **Drug Supply Chain Management:** Challenges with drug clearance have been identified as significant barriers to the effectiveness of MDA programmes in Nigeria. DFID will therefore contract Crown Agents to act as a clearing agent for donated NTD medicines coming into Nigeria.
- **Communication and Coordination:** Funding has been provided for behaviour change communication (BCC) /information education communication (IEC) at the state level. Provision has also been made to ensure coordination with existing health, WASH and education programmes to maximise synergies with complementary programmes.
- **Health Systems Strengthening:** Provision of technical assistance to the FMOH and state level for policy development and logistics, and costs associated with the recruitment and training of community drug distributors.
- **Sustainability:** Use of existing community mechanisms wherever possible and / or schools-based distributions to deliver the mass drug administration. Strengthening the community health platform and health systems strengthening activities will all contribute to sustainability.
- **Resilience / adaptation to potential fragility:** 3% contingency funding will address the uncertainties of implementing the programme, particularly in high risk states.
- **Evidence for decision making:** 5% funding is allocated for M&E to ensure that the programme can develop and improve during the implementation period, learning from challenges, sharing best practice and building a platform that will enable complementary operational research (if funding is available for this) to optimise programme effectiveness.

Section 3
Terms of Reference (Revised Sept 2017)

Budget

The programme budget from 1 October 2013 up to 30 September 2017 is £10,998,747, excluding funding for clearance of medicines and procurement of Praziquantel and goods and equipment, which have, prior to this current extension, been budgeted separately through a contract with Crown Agents.

An additional budget of £3,180,000 is available up to 31 March 2019 for the programme. This includes funding for clearance of medicines and procurement of essential goods and equipment for the programme.

Annex A – Risk Assessment Matrix

DFID Overall Project/Intervention Summary Risk Assessment Matrix

Project/intervention title: Integrated Programme Approach to Control a Range of Neglected Tropical Diseases (NTDs) in Nigeria
Location: Northern Nigeria
Date of assessment: 6 October 2017

Theme	**DFID Risk Score for Nigeria**
Overall Rating	**4**
Civil Unrest	4
Violence/crime	4
Terrorism	4

1 Very Low Risk	2 Low Risk	3 Medium Risk	4 High Risk	5 Very High Risk