

## **Notes from a site visit to Sightsavers' program in Accra, Ghana, August 14, 2016**

### **GiveWell participants**

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**Note:** These notes were compiled by GiveWell and summarize the primary observations and information learned from the site visit.

### **Summary**

GiveWell staff visited Sightsavers' program in Accra, Ghana as part of its review of Sightsavers as a potential top charity. They met with Sightsavers staff and a representative of the Ghana Health Service (GHS).

### **Meeting with Sightsavers staff**

#### **Sightsavers participants**

- Sunday Isiyaku, PhD – Country Director, Nigeria and Ghana, Sightsavers
- Elizabeth Elhassan, PhD – Technical Director of Neglected Tropical Diseases (NTDs), Sightsavers
- Didier Bakajika, M.D. – Programme Epidemiologist for NTDs, Sightsavers

### **Sightsavers' organizational structure**

Sightsavers' neglected tropical disease (NTD) work is spread across three main departments: finance and planning, NTDs, and policy and program strategy, which includes research. Sightsavers provides technical and operational support, and places a strong emphasis on operational research.

In Africa, Sightsavers has 11 country directors, some of whom cover multiple countries, and two regional directors: one for West Africa and one for East, Central and Southern Africa. Sightsavers has in-country staff and offices in some countries, and works entirely through implementing partners in others. Partners are primarily government actors, and sometimes NGOs. Countries that do not have a director based in-country include Guinea, Cote d'Ivoire, Guinea-Bissau, Burkina Faso, Togo, Niger, the Democratic Republic of the Congo, and Benin. Nigeria is one of Sightsavers' largest country programs.

Within country offices, country directors oversee the work of program managers, and program managers oversee the work of program officers. Each country office has a finance and support service team of 1-4 people, depending on the program portfolio of the country.

Program officers do most of the on-the-ground work. Their primary activities are providing technical support and monitoring; for example, they visit implementing

partners and communities to verify that the program is proceeding as planned, and provide technical support, like the training of implementing partners.

## **Sightsavers' role in mass drug administrations**

The primary activities of Sightsavers' program staff include:

- Visiting each state for 1-2 weeks per quarter
- Assisting with planning of activities, expenditures, and monitoring
- Training government staff on how to carry out and report on mass drug administrations (MDAs)
- Monitoring of program implementation
- Assessing the quality of data from MDAs
- Advocating for the government to commit more resources to the program
- Reviewing reports produced by governments for donors

Sightsavers' finance staff assess implementing partners' monthly reports and audit partners' accounting books every three months.

Technical advisors, such as Dr. Elhassan, visit and provide country programs with technical assistance, such as the development of concept notes and proposals. They disseminate new technical recommendations, analyze data, and discuss any issues related to program managers' trip reports and donor reports.

Sightsavers supports implementation costs, such as those related to planning meetings, monitoring and evaluation, vehicles, computers, educational materials, sensitization activities, and supervision. Sightsavers supports its partners' salary costs on some projects, where appropriate for operational reasons and where this has been built into the project and approved by the donor. Dr. Isiyaku and Dr. Elhassan noted that this is not the case in Nigeria and Ghana because this arrangement is not required. Implementing partners submit activity-based budgets to Sightsavers that include sufficient detail to verify, for example, precise per diem costs.

## **Types of mass drug administrations**

Sightsavers supports both community-based and school-based MDAs.

### **Community-directed interventions**

Through community-directed intervention programs, Sightsavers can reach high-need populations, such as children who do not attend school. Many children living in the areas where Sightsavers works are in this situation; as they are more exposed to dirt and river water through their daily activities, they are more likely than their peers to contract a severe infection.

The following issues might arise in community-based MDAs:

- Seasonal migrants might be absent during their community's MDA

- Volunteer community drug distributors (CDDs) do not always visit every household
- There might be barriers to adherence, such as mistrust of CDDs
- Some recipients might be systematic non-compliers
- People might fear side effects, especially in communities where serious adverse events (SAEs) have occurred

### **School-based mass drug administrations**

Sightsavers believes it is important to not only support school-based MDAs. Stakeholders in the soil-transmitted helminthiasis (STH) field are interested in covering people other than school children. Additionally, school attendance is quite low in some regions. As this is the case in Northern Nigeria, Sightsavers would plan to do both school-based and community-based distributions in that area.

A country's decision to treat adults for schistosomiasis depends on its access to appropriate amounts of praziquantel. As praziquantel donations are generally restricted to school-based programs, sometimes other implementers only do school-based MDAs for schistosomiasis. The World Health Organization (WHO) has granted three countries exemptions that allows them to treat adults with praziquantel. Ideally, Sightsavers would like to distribute praziquantel to entire communities.

In locations that are endemic for STH but not lymphatic filariasis (LF), Sightsavers endorses treating only children with mebendazole. However, if an area has an LF MDA program, there is no need to add an STH treatment unless STH rates are very high. If STH rates are high enough to merit a second round of treatment, that round can be school-based.

#### *School-based programs in Nigeria*

In Nigeria, implementing school-based programs in schools providing a Western education can be problematic, as attendance is often low. School-based programs are extended to Islamic schools to ensure high coverage. In both types of schools, parents are consulted to get permission for their children to be dewormed. In some cases where severe adverse reactions have been experienced, it can be difficult to get such permission. The programs therefore ensure that the children are fed before treatment to avoid the adverse reactions.

### **Integrated mass drug administrations**

#### *Benefits*

Sightsavers believes that it is significantly more cost-effective to run integrated NTD programs than separate ones.

The main approaches to integrating programs are:

- Combining planning and budget meetings in order to save time and resources, such as venue booking costs.

- When integrating community-based and school-based MDAs, combining training sessions for health workers and teachers who will be administering the same drugs. Health workers then train CDDs.
- Producing one training booklet that includes all of the necessary instructions
- Using a reporting form that captures the results of all programs, including each participant's name, age, sex, and doses of treatment received for each disease.
- Monitoring all of the distributions at once, so there is only one report to create and review.

### *Possible objections*

- **Confusion during training** – While Sightsavers agreed that this might occur, it explained that workers receive easy-to-understand booklets covering the protocols for each type of treatment. The content is also accessible to those who are illiterate. Additionally, MDAs occur directly after training, while the material is still fresh on volunteers' minds. Many have received the same training previously and have a thorough understanding of the material.
- **Consequences of taking multiple pills at once** – Sightsavers noted that not all drugs are given at once; for example, some are distributed in 2-week intervals. Also, there is now rigorous evidence on which drugs are safe to administer simultaneously.
- **Delayed distributions due to particular drugs arriving late** – Sightsavers noted that this was not a major problem because the drugs are designed to have a long shelf life. It noted that some drugs can be difficult to access; for example, albendazole in particular is known for coming in late and delaying distributions.
- **Members of communities where SAEs have occurred might not want to take other drugs** – Sightsavers noted that sometimes, individuals with high microfilaria loads who take ivermectin experience SAEs, including itching and severe swelling. SAEs are most likely to occur in co-endemic areas in the first year of treatment. People who have refused treatment in previous years are also at risk of experiencing SAEs. If a SAE has occurred in a community, its residents, and those of surrounding communities, might refuse to take the other treatments. It is not clear if implementing programs separately would prevent this from happening, but it might be easier to get people to comply with deworming treatments if there are no ivermectin treatments occurring in the area.
  - Sightsavers noted that SAE rates were higher at the inception of programs several years ago at the very beginning of the distribution of ivermectin, when there were insufficient adverse event protocols in place. Now, for any treatment program, it ensures that the local health clinic is stocked with medicine to treat SAEs, such as antihistamines for itching, or is otherwise equipped to handle them. Sightsavers also tries to educate communities about the signs of SAEs so that they can be treated early and deaths can be prevented; most adverse events

can be mitigated if the person receives treatment early. However, many communities remain unaware of the adverse event protocols and continue to fear possible negative outcomes.

- STH treatment does not generally lead to SAEs, though it can cause vomiting in some children, especially if taken without food.
- Treatment for LF can lead to SAEs, but this happens very rarely.

## **Challenges obtaining drugs**

The significant scale up of deworming programs sometimes makes it challenging for drug manufacturers to keep up with demand and for countries to obtain drugs. For example, countries that submit drug requests late, fail to respond to questions from suppliers or donors quickly, or fail to report on the use of the last shipment of drugs may not be able to receive future shipments in a timely manner. Due to their weight, some drugs, such as albendazole, must be transported by ship, which takes a considerable amount of time.

## **Neglected tropical disease work in Nigeria**

Gombe state has received NTD funding from the END (Ending Neglected Diseases) Fund; the program there is led by a local NGO, and Sightsavers provides some technical assistance.

UNICEF provides funding for NTD work in Benue state. Sightsavers would like to begin doing deworming work in Benue, and is seeking funding for this. However, despite the state's particularly high-burden worm load, Sightsavers plans to prioritize expanding deworming programs in the states in which it already works before launching programs in new ones.

NTD work in some states is funded by sub-grants to implementing partners such as CBM and Helen Keller International (HKI); in some states, these partners report to Sightsavers. For example, Sightsavers has used unrestricted funding to fund HKI's work in Nigeria.

## **Monitoring and evaluation**

### **Impact assessments**

If it had additional funding, Sightsavers would like to do more impact assessments. They can be quite costly; this is particularly true for assessments of onchocerciasis programs, which involve catching and analyzing flies. Sightsavers has an agreement with the Schistosomiasis Control Initiative (SCI) to conduct impact assessments in Nigeria.

### **Coverage surveys**

Sightsavers hires external consultants to carry out coverage surveys. The process is managed by its policy and strategy department. The coverage surveys that GiveWell received are the first that were fully funded by Sightsavers; previous ones were funded by other organizations.

Dr. Elhassan noted that Sightsavers has always followed a WHO protocol recommending that coverage surveys be conducted at a program's 1-, 3-, and 5-year marks. Dr. Elhassan believes that routine monitoring is more important than coverage surveys, because it provides information about on-the-ground implementation issues that can be used to improve programs. As the results of routine monitoring and coverage surveys often complement each other, comparing them can be a useful exercise. Sightsavers does not intend to do annual coverage surveys for any of its programs, as it believes this would be a poor use of funding.

Currently, Sightsavers is standardizing the format of its trachoma, onchocerciasis, and LF coverage survey questionnaires. A staff member might also be doing this for Sightsavers' STH and schistosomiasis coverage survey questionnaires.

#### *An example of coverage survey methodology*

Below we describe the methodologies used for recent coverage surveys conducted in Cote d'Ivoire, Burkina Faso, Benin, and Togo. Coverage surveys conducted in other locations have not used the same methodology.

- Districts are selected using a 30-10-1 sampling method: 30 villages are selected, then 10 compounds from each village, then 1 house per compound. On average, 6.5-7 people live in each house, which results in a sample size of approximately 1800 people.
- Surveyors follow a standard protocol. Surveyors are trained to ask a variety of questions to verify a participant's answer, such as questions about the pills' color, the number of pills taken, and whether or not a dose pole was used. The answers to these questions are not recorded; they are merely asked to help investigators determine whether or not the participant took the intended treatment. Many community members have been treated so many times and have heard public health messages, so they already know the names of the drugs and do not find the surveys confusing.
- If nobody is home, the surveyor visits another house in the compound where people are present. If nobody is in the compound, the surveyor chooses a nearby compound to visit. If some household members are absent, the surveyor does not ask those who are present whether the absent members received treatment. Instead, the surveyor marks that they were absent and does not include any information about them in the survey. The surveyor then checks the collected information against the CDD's register.
- Supervisors monitor the data that surveyors are collecting. For example, in a survey that took place in Cote d'Ivoire and Burkina Faso, there were six teams of three surveyors. Four supervisors (two teams of two supervisors) accompanied surveyors on their visits to listen to their interviews and check their forms to be sure they had been correctly filled in. If there were mistakes, these were corrected on the spot so that surveyors could improve as the day went on.
- In order to avoid recall bias among participants, all of Sightsavers' coverage surveys are conducted within 4-8 weeks after the MDA.

- Coverage surveys are only carried out where Sightsavers provided technical assistance and/or financial support to the area's MDA.
- In the final coverage calculations, participants who do not know whether or not they took the treatment are considered as not having taken it.

Sightsavers does not believe that coverage surveys for STH and schistosomiasis are significantly different from those conducted for the other NTDs it focuses on.

### **Routine monitoring**

In all MDAs, supervisors should conduct routine monitoring of the work of community CDDs by using checklists for each monitoring level (for example, local and national) and produce reports for the implementation areas. Sightsavers told us that it could share these reports, which differ from those generated through Sightsavers' newly developed quality standard assessment tool (QSAT). Sightsavers cannot yet share QSAT reports with GiveWell. However, Sightsavers shares relevant aspects of QSAT findings where donors have specifically funded the activities covered and where relevant partners have agreed to have these findings shared.

## **Funding**

### **Room for more funding**

Some countries that already have funding and implementing partners still face small funding gaps. This is partly because partners often prefer to expand services in the areas where they are already working, which can lead some areas to be neglected. In general, there is a lack of funding to cover all areas that need treatment.

Sightsavers has a limited amount of unrestricted funding. It would need additional funding to scale up deworming programs. For example, it currently uses unrestricted funding to fund its deworming programs in four states in Nigeria, but does not have sufficient funding to scale them up. The Nigerian government NTD policy enjoins all partners working in the NTD field to support integrated treatment for all NTDs.

NTD prevalence rates have already been mapped in most of the countries that Sightsavers would like to work in.

### **Funding for deworming programs vs. other neglected tropical disease programs**

Most NTD funders prioritize treating onchocerciasis and LF because both of these diseases have progressed from a control phase to an elimination phase in many countries. Both diseases have an elimination target of 2020 to 2025 in many countries.

Large-scale deworming treatment only started recently in many countries and is an ongoing control program, and current evidence suggests that school-age only treatment is insufficient for long term impact. Many NTD funders are long-time funders of onchocerciasis programs, and remain focused on its elimination.

*All GiveWell site visit notes are available at*  
<http://www.givewell.org/international/site-visits>