

Nigeria NTD Stakeholders Meeting

Potential SCI Involvement Scoping Document

Abuja, Nigeria – 18th – 21st May 2015

1. EXECUTIVE SUMMARY

1.1. Background

Nigeria held its national NTD Stakeholders meeting and NTD Steering Committee Meeting in Abuja between 18th and 21st May 2015.

SCI have previously provided technical assistance to the Sightsavers-led SCH/STH mapping of 14 states in Nigeria, and provide ongoing technical support on M&E activities, co-ordinated by Fiona Fleming.

SCI representatives have held informal discussions with Nigeria FMOH representatives at the Addis Ababa December 2014 meetings (Alan Fenwick and Lynsey Blair) and at the February 2015 RPRG meeting in Brazzaville (Mike French) to ascertain the need for support and potential opportunities.

SCI were invited to attend the stakeholder meeting, as were our colleagues from Evidence Action – Deoworm the World Initiative.

The administrative levels of Nigeria are: **6 geographical zones, 37 states** (36 states plus Federal Capital Territory), and **774 Local Government Areas** (LGAs, implementation unit).

Nigeria has just elected a new government, with the new president (His Excellency Muhammadu Buhari) due to take office on 1st June 2015. This has largely been a peaceful process to date.

1.2. Need

Mapping of all 5 PC-NTDs is well advanced, with approximately 95% of mapping completed. Funding is in place to complete the mapping in those areas that require it (mostly two states in North East of the country); although the constraining factor is security in these states (Borno, Adamawa, and a little of Yobe state).

Of the 774 LGAs in the country 724 have been mapped for SCH and STH. Therefore, 50 LGAs remain to be mapped (although 66 LGAs would be the optimum to map given that some data is old).

There is a strong group of NTD partners in the country and there is good co-ordination of the partners by the FMOH.

Implementation is currently split largely by state. 25 of the 37 states have a 'lead NGDO' who, in partnership with the state government, co-ordinate NTD activities in that state.

12 states have no active lead-NDGO.

In addition, several states that do have an active lead NGDO have yet to reach state-wide coverage for the control of SCH and / or STH (and the other PC-NTDs).

Therapeutic coverage of SCH and STH for 2013 is estimated to be **20%** and **35%** respectively. Figures for 2014 are not yet available but are not expected to exceed 50%.

Coverage of IDM NTDs is even further behind. Given that IDMs are not the expertise of SCI (or DtWI) the rest of the document will only focus on the PC-NTDs.

1.3. Possible involvement of SCI

There seem to be three possible avenues for SCI / DtWI involvement. These are not mutually-exclusive, and we could consider tailoring the approach to suit the funder being approached. These are for discussion.

Option 1 – Partner with an existing programme in a state or states. Approach a stakeholder that has a need and an openness to partner and which enable expansion to true state-level scale, or to expand to conduct all 5 PC-NTDs. Options for this would include RTI-ENVISION/TCC, MitoSath, eHealth Africa, HKI. For example, RTI-ENVISION would like us to partner with them in some states to conduct the SCH/STH treatment.

Option 2 - Implement in an orphan state. In those states where there is not an active programme, commence one. This could be done by partnering with an organisation that already has a presence in Nigeria, or setting up a presence. In addition, there may well be some smaller organisations (domestic mostly) to partner with. There may be some smaller organisations to partner with there. We would need to develop plans to treat all 5 PC-NTDs (if present), although this would not need to be done in the first year.

Option 3 – Provide some of the requested national-level support. This can include technical and financial assistance on co-ordination mechanisms, supervision, technical reviews, Monitoring and Evaluation, operational research.

1.4. Suggested Next steps

- Internal SCI discussion on possibilities. This will impact on the following steps:
- Commence process to join the NGDO network in Nigeria
- Discussion with DtWI on way forward - joint or separate projects
- Discussion of needs with RTI-ENVISION for expanding to state-wide, 5 PC-NTD coverage in states they already support
- Identify “orphan” states in which to commence activities and other organisations with which to partner.
- Identification of funders to be approached
- Due diligence trip to Nigeria and to selected states
- Development of proposal(s) and submission to funders

2. BACKGROUND

The SCI were invited to the Nigeria NTD Stakeholders Meeting (agenda attached – Annex 1). SCI had been involved in initial informal conversations with Nigerian Federal Ministry of Health (FMOH) NTD representatives at the Addis Ababa NTD meetings in December 2014 (Alan Fenwick and Lynsey Blair) and at the WHO-AFRO 2nd RPRG meeting in Brazzaville, Congo in February 2015 (Mike French).

SCI have previously provided technical assistance to the Sightsavers-led mapping of 14 states in Nigeria, and provide ongoing technical support on M&E activities, co-ordinated by Fiona Fleming.

As we have all been told countless times, Nigeria is the most populous country in Africa, with a population of approx. 170m people (~20% of Africans are Nigerian), and has the largest NTD burden on the continent, carrying 25% of the NTD burden, with the following relevant estimates:

- 120m people requiring treatment against LF
- 38m people requiring treatment against onchocerciasis
- **43m people infected with schistosomiasis**
- **35m infected with STH**
- 19.6m at risk of trachoma
- 5,000 new annual cases of leprosy (4th largest in Africa)

Nigeria is comprised of 6 geo-political zones, 37 states (36 'true' states plus the Federal Capital Territory of Abuja) and 774 Local Government Authorities (LGAs).

Each of the states where NTD activities are occurring is led by an NTD NGDO partner. These include The Carter Center / RTI-ENVISION (in partnership), UNITED consortium (Sightsavers, Helen Keller International, Mithosath, CBM, CNTD, LCNTDR), and UNICEF (Figure 1). However, it is clear that the previously UNICEF-supported states require significant additional support, that there are two truly orphan states where no activity is being undertaken, and even in those states with an active NGDO partner, treatment coverage (for all PC-NTDs) often falls significantly below state-wide level. all the 5 PCTs.

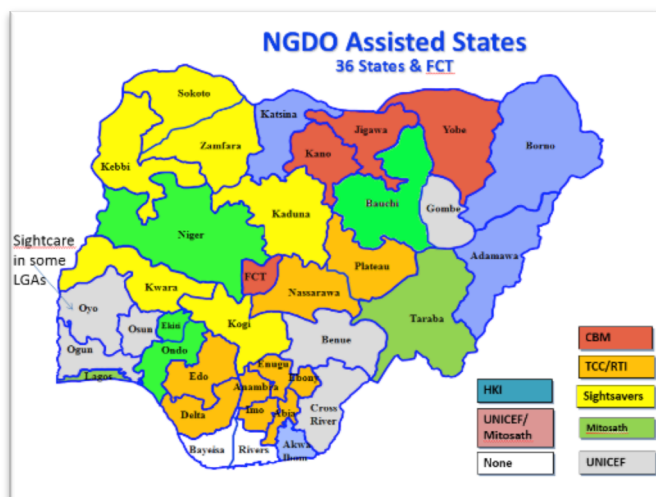


Figure 1. Current set up of NTD NGDO support to the 37 states plus FCT in Nigeria

2.1. Mapping

There has been great progress for mapping of the PC-NTDs. The majority (~95%) of the LGAs have been mapped for all diseases. Co-ordinated mapping has been undertaken by most partners: The Carter Center and RTI undertook combined trachoma / *Loa loa* / SCH and STH mapping in 9 states. CIFF and Sightsavers (**with technical support from SCI**) undertook combined SCH / STH mapping in 14 states. The Global Trachoma Mapping Project (GTMP) undertook combined trachoma / LF / SCH and STH mapping in 3 states.

Approximately 50 LGAs mostly in the insecure states in the North East of Nigeria remain to be mapped. Funding is available to conduct the mapping. Security is the issue.

2.2. Schistosomiasis epidemiology

724 of the country's 774 LGAs have been mapped. **603 LGAs are endemic and require intervention.** A further 66 LGAs need to be mapped (some of these are remapping due to old data). The results of the mapping can be seen below in Figure 2. It can be seen in the left hand panel of Figure 2 that the distribution of schistosomiasis (SCH) is widespread (any pink area indicates a SCH-endemic area). However, the right hand panel shows that treatment is only currently being conducted in a minority of those LGAs that require it (dark blue indicates where treatment is being conducted; light blue and light grey indicate that treatment is required but not yet being undertaken).

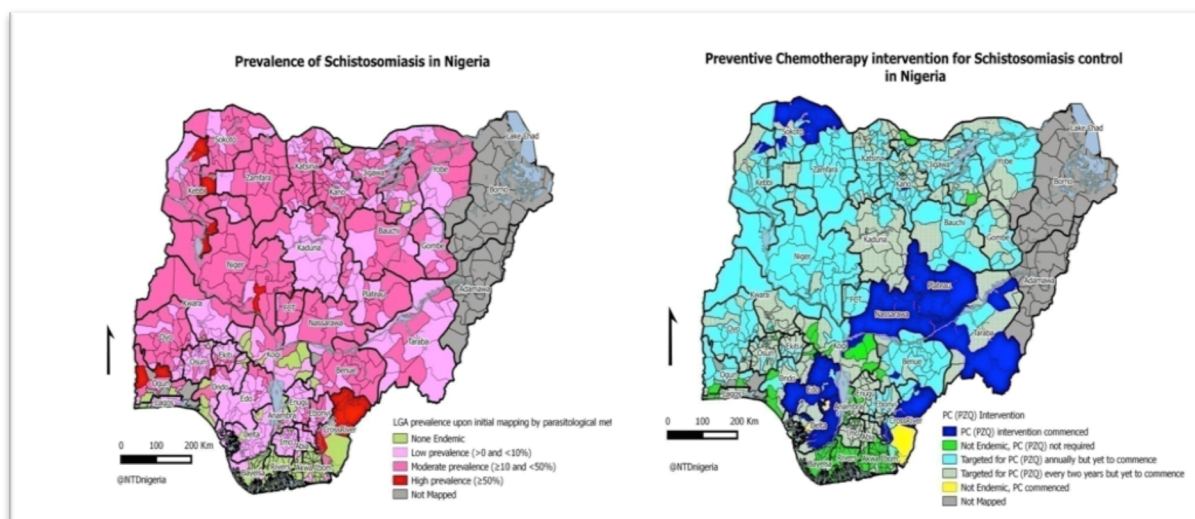


Figure 2. Distribution of schistosomiasis [SCH] (left-hand panel) and status of SCH control (right-hand panel). Dark blue areas indicate SCH-endemic areas where control has commenced. Light blue areas indicate SCH endemic areas where treatment has *not yet* commenced.

2.3. STH Epidemiology

724 of the country's 774 LGAs have been mapped. **459 LGAs are endemic and require intervention.** A further 66 LGAs need to be mapped (some of these are remapping due to old data). The results of the mapping can be seen below in Figure 3. Areas with medium or high STH infection (and which therefore qualify for MDA) are represented by red and dark brown colours in the left hand panel. In the right hand panel the dark blue colour indicates areas where treatment has commenced. Light blue and light grey colours indicate where treatment is required but has not yet commenced.

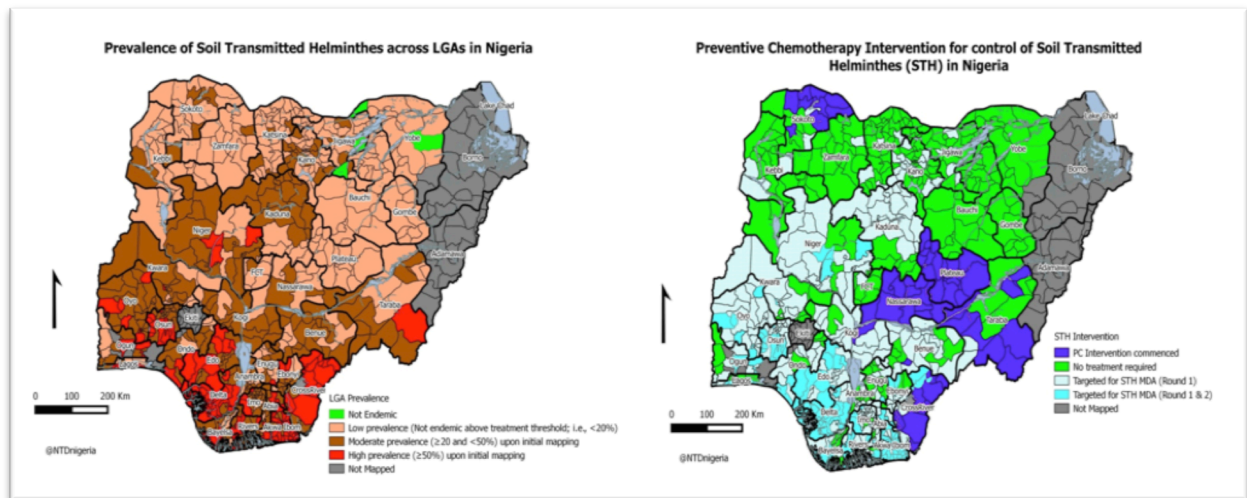


Figure 3. Distribution of STH (left-hand panel) and status of STH control (right-hand panel).

The clear message from this meeting and from related discussions is that there is still a significant need for support for SCH and STH control in Nigeria. Both in states with no active programme and in many states with a current active programme. This need for additional support is further evidenced by the FMOH’s scale-up / scale-down plans between now and 2020 (Figure 4). Note that 2010 – 2013 are confirmed numbers, 2014 onwards are projections. There is a very significant jump in planned treatment numbers between 2013 and 2014. Did this happen? Is it realistic? Part of the objective of this trip to attempt to get those numbers confirmed.

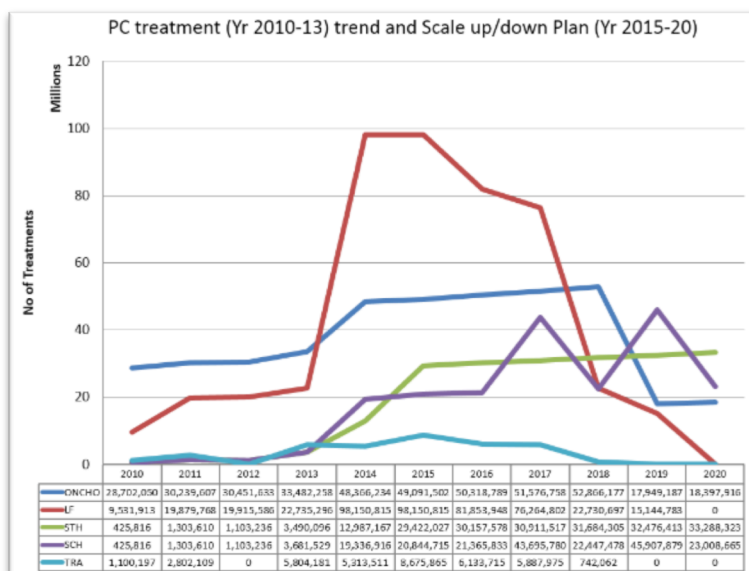


Figure 4. FMOH’s Scale-up / Scale-down plans for the five PC-NTDs in Nigeria from 2010-2020. Note that 2010-2013 are confirmed figures. 2014 onwards are projections

2.4. Possible Funding

The SCI does not currently have any committed funding specifically to support NTD work in Nigeria. The SCI’s business plan lays out the organisation’s expansion plans over the next few years. It states

that the priority for the use of any unrestricted funds is to reach national coverage in those countries which currently receive financial / technical support first, before entering new countries.

Of course, this does not preclude applying for restricted funding. Possible avenues for this include (we are open to further suggestions):

- The END Fund - they currently fund Mithosath to implement in one state in Nigeria)
- CIFF – Nigeria is one of CIFF’s five priority countries. They funded mapping in 14 states through Sightsavers. Will depend on outcome of proposed \$16.5m grant for SCH / STH control in Ethiopia
- Approach to GiveWell, GoodVentures – Both SCI and DtWI are high on the list of recommended charities. Could apply individually or make a joint approach. A joint approach from two recommended funders could be a powerful message.
- Other funders

3. OBJECTIVES OF TRIP

- Have clearer understanding of scale-up of SCH / STH treatment in Nigeria
- Understand remaining gaps for SCH / STH treatment
- Understand what role SCI could play
- Understand which organisations we could partner with, including Evidence Action – Deworm the World Initiative
- Understanding of NTD co-ordination structure in the country
- Possible funding sources
- Meet key partners and make connections

4. NOTES FROM STAKEHOLDER MEETING – DAY ONE

4.1. Welcome Remarks and objectives

The meeting was chaired (*excellently*) by **Dr. Uche Amazigo** – the former Director of APOC. Dr. Amazigo welcomed everybody to the meeting, especially those who had travelled from outside the country, and invited attendees to introduce themselves.

She thanked all of the partners who were already involved in the project, and potential new partners who were attending the meeting. These partners include: the UN, WHO UNICEF, The Carter Center, the Steering Committee of the Federal Government of Nigeria, Sightsavers, UNITED NTD Group, Children’s Investment Fund Foundation (although they were not present), RTI-ENVISION, Helen Keller International, HANDS (new group which has grown out of CBM), GNNTDC (now just know as Global Network, and who have opened an office in Abuja), SCI, Evidence Action - DtWI, Mithosath, Nigeria Leprosy Mission, Malaria Consortium, Accenture Development Partners, Vitamin Angels, Amen Foundation, Basic Health Foundation / Association, and The END Fund.

Dr. Amazigo outlined the **objectives of the meeting** which are to:

- Review the status of NTD programme implementation in Nigeria
- Assess the NGOs support for NTDs in Nigeria
- Assess the scale-up plans for PC-NTDs, gaps, and priority areas

Also the (*very closely related*) expected **outcomes of the meeting**:

- Status of NTD programme implementation in Nigeria received
- NGOs support for NTDs in Nigeria assessed
- Scale-up plan for PC-NTDs, gaps, and priority areas assessed.

4.2. Keynote Address – Dr. Ifeoma Anagbogu

Dr. Ifeoma – Assistant Director of the FMOH NTD Department delivered the keynote address on behalf of the Director of Public Health who could not be present.

Nigeria continues to make significant strides in the fights against NTDs. Nigeria is proud to have eliminated Guinea Worm. In 2013, the Federal Government of Nigeria launched a multi-year, integrated NTD plan. In addition, they are currently developing state-specific plans in order to identify those most at risk of infection and therefore those states most in need of implementation.

It is important that the public are seen as partners, not recipients.

4.3. Status of NTD programme implementation in Nigeria – Dr. Ifeoma Anagbogu

There are over 100m Nigerians at risk of infection or infected by 1 or more NTDs. The FMOH operates in a co-ordination role. It brings stakeholders together, provides policy guidance, resource mobilization, M&E guidelines, and does some filling the gaps.

The design of the co-ordination mechanism is from **National NTD Secretariat > State NTD Team > LGA NTD Team > Communities.**

Within the FMOH a central NTD team operates, which is comprised of representatives for Guinea Worm/Human African Trypanosomiasis, SCH/STH, Leprosy, Trachoma, Onchocerciasis/LF, and Rabies

Dr. Ifeoma provided the most recent programme coverage figures available (Table 1):

Year		Onchocerciasis	LF	SCH	STH	Trachoma
2013	Number	33.4m	22.7m	5.5m	5.4m	5.8m
	Coverage (therapeutic)	80%	24.9%	20% (approx.)	35% (approx.)	88%
2014		Data analysis still ongoing (<i>which is worrying that it is now end of May and there are not clear numbers on people treated during 2014. Especially as 2014 was projected to be such a large scale-up of treatment numbers</i>)				

Table 1. National treatment coverage figures for 2013 for the 5 PC-NTDs

The planning and co-ordination of NTD activities is undertaken by the NTD Steering Committee, which is comprised of the Government of Nigeria and NGO stakeholders.

Dr. Ifeoma highlighted Nigeria’s recent **NTD achievements**:

- Nigeria has been declared Guinea Worm Disease free – and is WHO certified
- Onchocerciasis transmission has been eliminated in ~ 15 states
- Lymphatic filariasis transmission has been interrupted in several parts of Plateau and Nasarawa states
- Leprosy – WHO target of <1 case per 10,000 population has been achieved nationally **(although this still equates to >3,000 leprosy cases of leprosy annually)**
- **94% of LGAs mapped for SCH / STH**
- 98% of LGAs mapped for LF
- 71% of LGAs mapped with REMO for onchocerciasis
- Onchocerciasis mapping needs delineation mapping in just 51 LGAs nationwide
- The national blindness survey was conducted in 2007
- In 2013 the NTD multi-year master plan was published (**can we get access to this document?**) and it has been domesticated into the plans of states.
- Integrated guidelines for malaria and LF treatment have been published
- A training manual for health workers and community supervisors has been developed and published
- Data management: All historic and current NTD data stored in the database (**but did Ifeoma say that some of the mapping data was still on paper forms and needed to be entered into the database?**)
- TIPAC has been used to generate PC medicine requests and master plans for costing. Some states have used TIPAC to develop master plans

Dr. Ifeoma also identified some of the **Key Challenges** for NTD activities in the country:

- Limited financial resources
- Increased security challenges – Borno and Adamawa state in the North East of the country in particular.
- The slow release of allocated funds at all levels of government
- The unavailability of funds for the distribution of ivermectin (51 LGAs in 11 states)
- Limited resources to complete *Loa loa* mapping in 195 LGAs.

Immediate Plans:

- Complete NTD Mapping and baseline surveys by the end of 2015
- Complete *Loa loa* mapping in all ivermectin-naïve LGAs by the end of 2015
- Strengthen collaboration with stakeholders and partners
- Scale-up NTD interventions to cover all eligible endemic LGAs
- Intensify high-level advocacy

Post 2020 activities:

- Shrink onchocerciasis map – with supporting evidence from epidemiological and entomological surveys

4.4. Status of NTD mapping – Dr. Obiageli Nebe

Dr. Nebe (SCH/STH focal person at the FMOH) provided an overview of the progress of mapping of NTDs. The status of mapping of SCH, STH, and LF is presented below in Table 2 (*the status of mapping for other diseases was also presented but I'm afraid I missed those*).

Infection	Total	Mapped	Endemic	Unmapped
LF	774	761	574	13 LGAs in Borno due to security constraints (HKI have agreed to support when safe)
SCH / STH	774	724	?	50 (Borno – 27, Adamawa – 21, Yobe – 2)

Table 2. Status of mapping for LF and for SCH/STH. The numbers indicate number of LGAs

CIFF partnered with Sightsavers (as part of the UNITED consortium) to map in 14 states. This then leveraged mapping in other states, such as those supported by RTI-ENVISION, and HKI / GTMP. All of these activities were conducted in collaboration with USAID and UKAID.

The Global Trachoma Mapping Project (GTMP; in partnership with HKI) is ready to support mapping in Borno and Adamawa states as soon as it is safe to do so. These states are still classified as being in a category 2 state of emergency. So, although the partners consider it safe to work in many of these LGAs (for instance, HKI think it is safe to work in 19 of the 21 LGAs in Adamawa state) they are officially prevented from doing so.

Dr. Ifeoma said that Clarity was needed on what support is required for both mapping and MDA activities, broken down state by state, and LGA by LGA. (*Yes, this is very important and would help hugely for our planning needs. This was promised but is still outstanding. To follow up*).

Funding: Let us be clear about what funding is available for what (mapping and MDA) and from whom. Dr. Cephas from WHO gave the strong impression that there were no funding gaps for mapping. Although after discussion it seemed that some of this money was with the partners rather than with the country so still some work to be done.

4.5. Ordering and arrival of drug donations and treatment of target groups – Dr. Obiageli Nebe

Dr. Nebe also discussed the **barriers to scale-up**. One of the main barriers is the ability to clear drugs which was identified as a priority by many partners. The update on drugs is that:

- Albendazole: 100m tablets are clearing at the port today
- Mebendazole: Recently delivered to the medical store
- Praziquantel: It seems to have arrived
- Zithromax: 2015 allocation is due to be delivered in July / August

The issue of drug ordering / arrival prompted a lot of discussion, with particular input from Chris Ogoshi (HANDS) and Frank Richards (The Carter Center). The point was made that we are now five months into the year and the drugs are still being cleared / on their way. We need drugs to be in place by November / December of the previous year as it used to be done in the 'golden years' (*this would be wonderful for programmes in all SCI-supported countries*).

This raises the valid question of whether we will use the same CDDs to implement who were trained months ago, or do they need refresher training? For a change in the drug ordering / delivery

mechanism we need high-level advocacy and we also need all partners to advocate for this with WHO. The funders themselves can be a powerful advocate here. As an example he said that they get asked by their funders why they are behind with their disbursement plan in the year. And the simple answer is that they cannot spend any significant money if there are no drugs to distribute.

In Nigeria it is better to treat before the rainy season (rainy season runs from May to July). If twice yearly treatment is required (e.g. with ALB for STH) then treatment before June is required. Now it is the end of May and the drugs are still in the port. Dr. Cephas reiterated that the best time to treat was during the dry season. Frank Richards added that this will also hold for malaria treatment; the best time to treat is before there were any mosquitoes about.

Recommendation from Chair: Frank Richards to come up with recommendation action on this. He said that previously he had arranged for Jimmy Carter to contact Margaret Chan directly.

Elizabeth Elhassan (Sightsavers – Ghana) stated that the quantity of medicines is much greater than before, for example the Mectizan Donation Program donations have increased a lot.

4.6. General Discussion

4.6.1. Treatment of non-enrolled children and in urban areas

Treatment of non-enrolled children – it is estimated that there are 10 million non-enrolled children in the country. What is the best way of reaching these? **(There was no real answer/conclusion to this, and this could be an areas where pooling the experiences from SCI-supported countries could be very useful as a way forward).** It seems that a combination of CDDs and school-based deworming is used in the country. Although there are FMOH guidelines on this (use school-based deworming for SCH/STH is recommended) this seems to be determined at the state level, mostly by the lead NGDO.

Treatment of non-enrolled children – SCI / DtWI / Sightsavers to write a document on this.

Strategies for reaching non-enrolled children.

Treatment in urban areas – can we just take CDDs and use them in urban areas? Probably not, need specific approaches here.

4.6.2. Process for new partners to get involved

Dr. Amazigo asked for clarification of how new NGDOs could get involved in states. Or do the current NGDOs want to keep the states all for themselves? **(She was asking the question on our behalf, which was nice of her).**

The Carter Center said they were open to new NGDOs in the TCC-supported states. They feel they have most of the capacity and money to do it already. But if there was a need then they would welcome new partners. They have a need for drugs. Whether it is a local or an international NGDO, the process is the same, to apply to the NGDO network in the usual way.

The Amen Foundation are open to new partnerships. They are undertaking MDA of LF / SCH / STH in Gombe State

4.7. Overview of the NGDO Stakeholders Coalition / Group – Chris Ogoshi – HANDS Group

Current **members** of the NGDO Stakeholders group are:

- The Carter Center / RTI-ENVISION
- Mithosath
- Sightsavers
- CBM / HANDS
- Helen Keller International
- Netherlands Leprosy Relief
- Amen Health Foundation
- Basic Health Foundation
- Others – Leprosy Mision, Malaria Consortium

The checks and balances of the stakeholders group lie with the FMoH.

Key **activities** of the group are:

- Advocacy – Global Network is on board now to assist with this
- Technical and Administration support
- Capacity building for health staff

Challenges:

- The payment of counterpart funds by assisted states has not been forthcoming
- Insecurity
- Integration, which with all its benefits is still very challenging
- Poor funding and visibility of Morbidity Management and Disease Prevention (MMDP)
- Insufficient number of CDDs. Should incentives be used (this led to a lot of debate – currently there are no financial incentives for CDDs – see below for further discussion)
- Late arrival and clearance of drugs
- Poor literacy levels of some CDDs
- Difficult terrain
- Attrition rate of CDDs. The quality of the cadre of CDDs keeps deteriorating as good CDDs leave
- Drugs sometimes refused due to apathy from the public – “my child feels well now...”
- High cost of MDA in ivermectin-naïve areas
- Lack of funding for scale-up
- Additional funding required to support expansion of *SCH / STH in already supported states*

Way forward

- Step up advocacy and sensitisation of political officers including the new president who is just now taking office new president in office
- Increased focus on MMDP
- Early drug delivery
- Incentives to CDDs

Chris Ogoshi gave an overview of how he selected states situation came about. It began about 20 years ago and was driven by UNICEF. However, now UNICEF is no longer able to conduct large-scale MDA delivery in their states. They do perform the clearance of drugs and conduct review meetings.

New NGOs wishing to contribute to NTD control in the country should consider:

- Orphan States
- Previously UNICEF-supported states

The process for becoming part of the NGSO network is to make contact with the FMOH first (Ifeoma and Nebe) and then approach the chair of the NGDO network stakeholders group (which is a revolving 12 month position – and is currently Chris Ogoshi from HANDS).

4.8. Scale-up plan for PC-NTDs, gaps, and priorities – Dr. Chukwa – FMOH

Dr. Chukwa from the FMOH reminded the group that we are discussing how we ‘scale-up’, and not how we ‘initiate’ as many of these programme have been running for a number of years. For example, APOC has been operating in Ethiopia for 20 years.

Dr. Chukwa presented the results of 2013 geographic coverage (not therapeutic coverage, Table 3)

Onchocerciasis	LF	SCH	STH
92%	71%	45%	61%

Table 3. National treatment coverage figures for 2013 for the 5 PC-NTDs

Treatment figures for 2014 are still not available (unofficial figures from just the TCC stages for 2014 are 2.7m treated for SCH and 7.7m for STH).

Activities with some support:

- Mapping
- Capacity Building
- Co-ordination
- Review Meetings
- Planning
- Data Management
- Production of IEC materials

Activities with little / no support:

- Monitoring and Evaluation
- Supervision
- DQA
- Office Equipment
- Vehicles – **big push to get partners to commit to purchasing vehicles, but no firm commitments forthcoming**

Summary of ‘Orphan’ states and UNICEF-supported states (which aren’t really supported). Number of LGAs in each state requiring treatment are shown in Table 4:

Infection	Bayeba	Rivers	Cross	Osun	Oyo	Ogun	Benue	Gonbe
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			Rivers					
SCH	2	1	6	28	33	20	22	11
STH	5	21	9	30	33	15	17	-

Table 4. National treatment coverage figures for 2013 for the 5 PC-NTDs

Other states in need of support (all located in the North East and so suffering from security constraints) are Adamawa, Borno, and Akwa Ibom.

4.8.1. General Discussion

Incentives for CDDs. This raised quite a lot of discussion, disbursed across the days of the meeting. Historically, some NGOs provided incentives to CDDs and some did not, and those that did provide incentives did so at different levels which distorted the system, particularly from the polio programme which was seen as a lucrative programme to work on. Currently, for the NTD control programme, non-financial incentives are used, such as raincoats and certificates.

The question that was asked is what do the CDDs value and how does this vary by geographical area?

Research – We need to ensure that the research output of the programme is maximised. Need to ensure that publications results from this work.

APOC Gap – Now that support from APOC is being wound down so much, the combined group of partners here need to address who will take over the support that APOC previously provided. One the big areas for this is vehicles for programmatic activities. Many programmes use APOC-procured vehicles. Who will fill this gap?

ADP Insights – One of the main constraints seems to be getting the drugs into the country. The UNITED coalition are expanding their programme from 3 states to 5. Issues around sustainability and transition from donor-led programme are key things to look at. This is one of the elements that ADP has been contracted to look into for the UNITED coalition.

ACTION: Speak to Vanessa about plans / processes for transition. DtWI look into this – hiring a transition manager in some of their countries

The END Fund – The END Fund are supporting Mithosath to operate in one state – Akiti.

4.9. IDM and Zoonotic Intervention – Dr. Balami / Mr Adebayo

Dr. Balami provided an overview of the Innovative Disease Management (IDM) NTDs in Nigeria. These include leprosy, Buruli ulcer, leishmaniasis, HAT, and rabies. It is clear that these are getting left very much behind and have been hardly mentioned during this stakeholders meeting. There are partners attending, such as the Netherlands Leprosy Mission, but they are in a minority. Are we serious about attacking IDM NTDs? **There was no real answer to this but I would say that the silence was deafening.**

4.10. Global Network and Advocacy - Dr. Francis Ohanyido

Dr. Ohanyido presented the work of the Global Network for NTD control (now known just as the Global Network), and advocacy initiative of the Sabin Vaccine Institute. Dr. Ohanyido is the new national NTD advisor for the global network and is based full time in Abuja, working from the Management Sciences for Health office. The Global Network’s role is one of advocacy. They bring

governments and partners to the meeting and unlock money in the government coffers. Our role is advocacy. We bring government and partners to the meeting and unlock money in government coffers. They advocate directly to the federal and state levels to sustain and increase political will and funds for NTD programmes.

They hope their work will eventually contribute to making Nigeria join the likes of the BRIC (Brazil, Russia, India, China) countries (moving from BRIC to BRINC).

The Global Network support the national NTD steering committee.

Currently, the 2015 Federal Budget does not include NTDs. They have a two-pronged suggested response:

- A joint letter from the NTD Community letter to President-elect highlighting the impact of NTDs, their extent in Nigeria, and the partnerships and donations already in place to treat them
- Appointing an NTD champion to speak on behalf of the NTD community; to act as Nigeria's NTD special envoy. They have approached H.E. Abdulsalam Abubakar – Former Head of State of Nigeria

Both of these will be covered in more detail in the following day's Advocacy and Resource Mobilization meeting (see below).

5. ADVOCACY AND RESOURCE MOBILIZATION SUB-COMMITTEE

On the second day the group split into four sub-committees:

- **Advocacy and Resource Mobilization**
- **Research**
- **Elimination and verification**
- **Technical Review**

I attended the Advocacy and Resource Mobilization Subcommittee. This was chaired by Dr. Emmanuel Meri, the country director of The Carter Center. It included representatives from the FMOH, TCC, Mithosath, Helen Keller International, Global Network, SCI, DtWI

Dr. Emmanuel opened the meeting and invited introductions. The output of the day's work would be a presentation that would be given to the steering committee tomorrow.

The terms of reference of the sub-committee were agreed as:

- Facilitate appropriate strategy for advocacy and resource mobilization
- Facilitate linkages and networks that advance advocacy and resource mobilization.

The main body of the meeting involved the discussion and development of two advocacy documents that had been prepared beforehand by the Global Network (Gechi and Francis). Where advocacy is defined as targeted discussions with policy makers, with the aims of:

1. Raising knowledge amongst policy makers

2. Moving them into action, through increasing funds available.

Identifying opportunities for resource mobilization will be conducted separately.

5.1. Draft Schedule of Activities

This memorandum (which is included below) includes a list of suggested advocacy activities to be implemented over a 12 month period, commencing from September 2015 (the date of the next stakeholders meeting).

The activities were divided into two section: those that can be carried out by the sub-committee, and those that can be conducted by individual members of the stakeholders' group:

Memorandum

To: Dr. Adenike Abiose, Chair of the National NTD Steering Committee and Advocacy and Resource Mobilization Working Group

From: The Global Network for Neglected Tropical Diseases

Date: May 14th, 2015

Subject: Draft Advocacy and Resource Mobilization Working Group Strategy, 2015-2016

Introduction

This document offers suggestions for key advocacy and resource mobilization (ARM) activities that the Nigeria National NTD Steering Committee (SC) ARM working group may consider. While not all activities can be implemented in the proposed timeline of Sept 2015 to Sept 2016, the ARM working group can select a few activities of focus

Suggested Activities

Activities outlined here are organised in two categories – those that can be carried out by the ARM working group and those that can be conducted by individual S.C. members.

NTD SC ARM ACTIONS				
#	Strategy / Objective	Action	Proposed Lead	Timeline
1	Conduct high level advocacy targeting new Government Officials	Send a welcome letter to the new President requesting that NTDs be a priority in the Nigerian development agenda	NGDOs in the SC	June 1 st , 2015
		Write to all key government offices highlighting the guinea worm successes and the challenge for NTDs specifying what they could do. Targets: Ministry of Finance, National Planning, Commission, Ministry of Water Resources	ARM	July-Aug 2015
		Plan roundtable discussion with ARM Working Group and key line ministires to discuss opportunities for collaboration Note: Suggest initial focus on NPHCDA to align on joint advocacy regarding National Health Act and MNCH weeks	FMOH	Sept 2015
		Plan an NTDs – WASH Forum (identify clear areas of integration and synergy)	ARM	2016
		Participate (and present if possible) in at least one other steering committee meeting for other health issues e.g. Malaria, Nutrition	ARM Representative	2015-2016
		Ask states to identify policies nad funding challenges and share these surign program managers meetings	DMOH	May and Sept 2015

		Note: Suggest focus on LGA level challenges to allow partners to respond specifically		
		Share SC meeting communique with FMOH, donors and all partners	FMOH	<30 days after each SC meeting
		Send SC memo, signed by FMOH, to each State MOH highlighting challenges and what needs to be done	FMOH	60 days after each SC meeting
		Send a letter asking state governors and LGA chairmen to sign-on to a pledge committing to finance NTD programs in budget for 2016 (NTD pledge)	AMR	August 2015
2	Establish and activate NTD Champions Forum	Identify at least 2 NTD champions and write official letters, signed by NGDO, inviting them to be NTD champions	ARM	July 2015
		Hold a high-level press conference introducing NTD Champion(s)	ARM	Sept 2015
		NTD Champion presentation to Governors OR National Assembly. Note: Plan this before budget acts are passed in 2016 as a last push for financing	ARM	March 2016
3	Share NTD successes with policymakers, public, donor partners and the media	Publish an op-ed/blog post on key highlights in the country (suggested first post on the completion of mapping)	ARM	2 posts / year with first post in Aug 2015 and second in Nov 2015
		Develop talking points and briefing materials for the ARM working group when journalists attend SC meetings and schedule at least 2 interviews during SC meeting	ARM	Aug 2015
		Consider Annual NTD dialogue as a possible advocacy platform with key policymakers and CSOs	ARM	1/year

Individual Actions

#	Strategy / Objective	Action	Proposed Lead	Timeline
1	Share NTD successes with policymakers, public, donor partners and the media	Include NTDs in discussions with policy makers and utilize talking points provided by the ARM	SC	Ongoing
		If you do any journal, blog or other publishing, consider including your affiliation to NTDs and SC	All	Ongoing
		Submit abstracts for ASTMH and NNN conferences	SC	TBC

5.2. Memorandum to the incoming President of Nigeria

The second document reviewed was a draft letter to be sent to the incoming president of the Federal Republic of Nigeria (His Excellency President Muhammadu Buhari). This letter outlines:

- The impact of NTDs
- The huge burden that Nigeria harbours (in terms of absolute numbers and relative to other countries)
- The great progress that has been made in the country to date (particularly with respect to the elimination of guinea worm)
- That tools exist and drugs are donated
- That partner commitment is strong
- BUT that much more needs to be done if Nigeria is to be a leader for SSA by 2020 and achieve the international goals

I can provide a copy of the updated letter when it is sent through

6. SIDE MEETING WITH FMOH

On the evening of the second day we held a side-meeting with representatives from the FMOH to identify where the FMOH's priorities were and to discuss where any potential SCI and / or DtWI support could be offered.

Present: FMOH: Dr. Ifeoma Anagbogu – Acting head of NTDs. Dr. Obiageli Nebe – Assistant Director Coordinator and National De-worming Programme. Ekenne – Programme officer for SCH / STH. Jacob – Programme officer for SCH / STH.

SCI: Mike French

DtWI: Jessica Harrison

6.1. Introductions and background

Dr. Ifeoma welcomed us to Nigeria and said she was glad that we had come. We could see that there was an exciting movement and progress behind NTDs in Nigeria. Also that there were still gaps and opportunities. We will have seen that about 95% of LGAs have been mapped – and those that have not been mapped have security constraints – they are classified as Security Category 2 – which makes it very difficult to work in. Actually, many of them are safe to work in right now but because of this category any fieldwork is impossible.

The NTD Master Plan was published in 2013. ***A copy of this to be provided.***

Mike asked the question of whether they collaborate with the FMOE and the extent of the collaboration. Yes, of course is the answer. There is no way we could implement through schools without the support of the FMOE. They are part of the steering committee. ***But they have not been part of these meetings I don't think***

6.2. Treatment numbers of SCH / STH

Treatment numbers for 2013: SCH is under 6 million people, which equates to approximately 20% of the need. STH is 5.4 million which equates to approximately 35% of the need.

Treatment numbers for 2014: These are as yet unconfirmed but are likely to be below 50% for both SCH and STH.

Drug donation: Nigeria have been allotted **21-22m tablets of PZQ** from WHO-Merck for the calendar year 2015. They have **20m tablets of albendazole** for STH treatment for the same period.

They confirmed that the availability of drugs is not the problem. As expected, the problem is having the money to implement and to supervise and to train. There is a clear need to step up the treatment.

The Federal Government are working towards harmonised protocols for treatment of SCH and STH. Currently there is a combination of school-based and community-based treatment operating around the country. In some ways this is a relic from the past, when the base for treatment was APOC and therefore tended to be community-based. In some states where SCH/STH treatment has been added to the APOC framework then treatment is community based. But the recommendations are for school-based treatment to reach SAC and additional outreach activities to reach adults and some non-enrolled.

6.3. Joining the NGDO Network and MoUs with the Federal / State government

Dr. Ifeoma said that it was not difficult for organisations like SCI and DtWI to join the NGDO network. The approach would be to write formally to the current chair of the network, Chris Ogoshi from HANDS, referring to the discussions we had held with the FMOH and with him yesterday. The answer will be yes.

The Federal government will introduce you to the state government. An MoU will be required with the Federal Government, but will probably not be required with the State Government.

6.4. FMOH's priority areas

Dr. Nebe welcomed us to Nigeria. ClFF came two years ago on a fact-finding mission, originally saying they could not support Nigeria but after the fact finding trip they committed. The information available on NTDs in the country is much richer now.

There are still some gaps though. These were the areas that they mentioned:

- There is mapping data collection from 12 stages that is currently sitting on paper forms. This should be entered in the same electronic database format as the rest of the data. ***Perhaps this is something we could help with***
- We need scale-up in order to reach all those who require treatment against SCH / STH (as well as the other PC-NTDs). SCH and STH have low coverage so far. Related to this, many partners ignore the 'low' schistosomiasis prevalence category (below 10%). These areas need to be reached if Nigeria is to reach the 2020 goals.
- We need training of teachers and Community Health Workers

- IEC materials are a priority. We go into schools and see lots of materials for HIV / AIDS but few for NTDs. And, in particular, SCH is the works for IEC. ***This should be something that would be possible to help with quite quickly***
- There is a need for operational vehicles. Especially as APOC wind down their support this year. ***No commitment was made on the supply of operational vehicles***
- Expansion of M&E activities (see paragraph below)
- Expansion of vector control and WASH activities
- Co-ordination of policy and guidelines
- Capacity development
- Supporting attendance at national and international meetings (which provides a good opportunity to share experiences with other countries)

Mike asked about the approach to monitoring and evaluation in the country. Is there a co-ordinated approach set by the Federal level, or do the states, and their respective NGDO partners, set their own M&E agenda. Dr. Nebe / Ifeoma said that the FMOH is trying to co-ordinate on this and provide guidance. The amount of M&E taking place is slowly increasing but there is still some way to go. What SCH / STH M&E that has been implemented has shown impressive results. For instance, some M&E data were collected from five SCH / STH sentinel sites. The results demonstrated a dramatic reduction in infection prevalence and intensity.

The FMOH are encouraging an integrated approach to M&E. They are using the RTI-WHO tool TIPAC for planning and they are using the WHO-RTI integrated NTD database for storing the data being generated by the programmes. RTI contracted a short-term consultant to support M&E in Nigeria.

6.5. Possible areas of support

We see three potential options for how we could get involved. These are not mutually-exclusive, and we could consider tailoring the approach to suit the funder being approached. These are for discussion.

Option 1 – Partner with an existing programme in a state or states. Approach a stakeholder that has a need and an openness to partner and which enable expansion to true state-level scale, or to expand to conduct all 5 PC-NTDs. Options for this would include RTI-ENVISION/TCC, MitoSath, eHealth Africa, HKI. For example, RTI-ENVISION would like us to partner with them in some states to conduct the SCH/STH treatment.

Option 2 - Implement in an orphan state. In those states where there is not an active programme, commence one. This could be done by partnering with an organisation that already has a presence in Nigeria, or setting up a presence. In addition, there may well be some smaller organisations (domestic mostly) to partner with. There may be some smaller organisations to partner with there. We would need to develop plans to treat all 5 PC-NTDs (if present), although this would not need to be done in the first year.

Option 3 – Provide some of the requested national-level support. This can include technical and financial assistance on co-ordination mechanisms, supervision, technical reviews, Monitoring and Evaluation, operational research.

We asked the FMOH whether their preference would be for us to implement in a state/s with an existing partner or in an orphan state. They said they both would be welcomed but if only one were possible then the preference would be for an orphan state.

6.6. Suggested Next steps

- Internal SCI discussion on possibilities. This will impact on the following steps:
- Commence process to join the NGDO network in Nigeria
- Discussion with DtWI on way forward - joint or separate projects
- Discussion of needs with RTI-ENVISION for expanding to state-wide, 5 PC-NTD coverage in states they already support
- Identify “orphan” states in which to commence activities and other organisations with which to partner.
- Identification of funders to be approached
- Due diligence trip to Nigeria and to selected states
- Development of proposal(s) and submission to funders

7. FOREIGN OFFICE SECURITY ADVICE FOR NIGERIA



8. MAIN PEOPLE MET

Federal Ministry of Health

- Dr. Ifeoma Anagbogu – Acting Head of NTDs
- Dr. Obiagel Nebe – Assistant Director Coordinator and National Deworming Programme
- Dr. Chukwa – Federal Ministry of Health
- Dr. Margaret Mafe – Research Director

The Carter Center

- Emmanuel Miri – Country Director, Nigeria
- Frank Richards – Director
- Lindsey Rakers – Associate Director
- Emily Griswold – Associate Director

RTI-ENVISION

- Scott McPherson – Resident Technical Advisor – Ethiopia and Nigeria – handing over Nigeria to:
- Alexis Serna – Technical Advisor
- Benjamin Nwobi – Resident Programme Advisor – Nigerian
- Joshua Sidwell – Sub award Manager
- Samson Rufus – M&E Manager

HANDS

- Chris Ogoshi – HANDS project (grew out of CBM, and chair of Stakeholders Group)

Global Network

- Wangechi Thuo – Global Network
- Francis Ohanyido – Global Network

Sightsavers

- Sunday Isiyake – Sightsavers
- Safiya Sanda – Sightsavers
- Ibrahim Nazaradden - Sightsavers
- Elizabeth Elhassan – Sightsavers Ghana

The END Fund

- Scott Morey
- Carlie Congdon

Others

- Uche Amazigo – Former APOC Director, Chair of meeting
- Dr. Ima Chima – Country Director, HKI
- Vanessa Gould – ADP
- Jack Lancaster – ADP
- Judith Edokpa – Netherlands Leprosy Relief – M&E
- Moses – Leprosy Mission
- Mithosath

9. ANNEX 1: AGENDA

Stakeholders/Inauguration Meeting on Neglected Tropical Diseases on 19th May, 2015 at Federal Ministry of Health conference room 6th Floor, Federal Secretariat Phase 3, Abuja.

Draft Agenda

S/N	Agenda Item	Period	Responsible Person
<i>Opening Ceremony</i>			
1.	Registration of Participants	8:30 – 9:00am	NTD Secretariat
2.	General Introduction	9:00 – 9:10am	Participants
3.	Welcome Address	9:10 – 9:15am	Dr. Ifeoma Anagbogu
4.	Opening Remark	9:15 – 9:30am	DPH
5.	Goodwill Messages	9:50 – 10:00am	NGDO Chair/WHO/ UNICEF NTD SC Chair
6.	Keynote Address & Inauguration of Oncho Elimination	10:00 – 10:10am	HMSH
7.	Vote of Thanks	10:10 – 10:15am	Dr. Yisa Saka
8.	Tea Break	10:15 – 10:30am	All
<i>Technical Session</i>			
9.	Definition and basic concepts of NTDs(Elimination, Eradication & Control) in Nigeria	10:30– 10:45am	Prof. Kale
10.	Status of NTD Programme Implementation in Nigeria	10:45- 11:00am	Mrs. Anagbogu
11.	Status of NTD Mapping	11:00 – 11:30am	Dr. Nebe/Mr. Davies
12.	Discussions on Presentations	11:30 – 12:05pm	Chair
13.	NGDOs support for NTDs in Nigeria	12:05– 12:20pm	Mr. Ogoshi/Dr. Maxwell/Dr. Udoh
14.	Scale up Plans for PC-NTDs, Gaps & Priority Areas	12:20– 12:30pm	Dr. Y. Saka
15.	Strengthening IDM & Zoonotic -NTDs Interventions	12:30- 12:40pm	Dr. Balami/Mr. Adebayo
16.	Discussions on Presentations	12:40- 1:00pm	Chair
17.	Lunch Break	1:00- 2:00 pm	All
18.	Briefs & Presentations by Partners and Stakeholders	2:00-2:25pm	Partners
19.	Support for Nigeria's NTDs through Advocacy	2:25-2:50 pm	Dr. Francis GNNTD
20.	Using published data on NTD activities for improved programme Implementation	2:50-3.30 pm	Prof. Akogu
21.	Discussions on Presentations	3:30-4.00 pm	Chair
22.	A.O.B	4:00-4.25 pm	Chair
23.	Communiqué	4:25-4.45 pm	Rapporteurs
21.	Wrap-Up & Closing/Tea break	4:45-5.00 pm	Chair