

**Mid–Term Evaluation - Northern Nigeria
Integrated Neglected Tropical Diseases Control
(UNITED) Programme, Nigeria**

Project Number 44031

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List of acronyms and abbreviations

ADP	Accenture Development Partners	MNCH	Maternal Newborn Child Health Programme
APOC	African Programme for Onchocerciasis Control	MOE	Ministry of Education
BCC	Behaviour Change Communication	MoH	Ministry of Health
BU	Buruli Ulcer	NGDO	Non-Governmental Development Organisation
CBM	No longer an acronym - formerly Christoffel Blindenmission	NGO	Non-Governmental Organisation
CDD	Community Drug Distributors	NSHDP	National Strategic Health Development Plan
CDI	Community Directed Intervention	NTCP	National Trachoma Control Programme
CDT	Community Directed Treatment with Ivermectin	NTD	Neglected Tropical Disease
CHD	Child Health Days	NYSC	National Youth Service Corps
CIFF	Children's Investment Fund Foundation	PATHS	Partnership for Transforming Health Systems in Nigeria
CNTD	Centre for Neglected Tropical Diseases	PCT	Preventative Chemotherapy
CSO	Civil Society Organisation	PHC	Primary Health Care
DFID	UK Department for International Development	PMO	Programme Management Office
EPI	Expanded Programme on Immunisation	RTI	RTI International
FCT	Federal Capital Territory	RTI-ENVISION	RTI led USAID funded global NTD control programme
FGD	Focus Group Discussions		
FLHF	Front Line Health Facility	SAFE	Surgery, Antibiotics, Facial Cleanliness and Environmental Improvement
FLHFW	Front Line Health Facility Worker		
FMOH	Federal Ministry of Health	SCH	Schistosomiasis
GSK	Glaxo Smith Kline	SCI	Schistosomiasis Control Initiative
GWD	Guinea Worm Disease	SMOH	State Ministry of Health
HAT	Human African Trypanosomiasis	STH	Soil-Transmitted Helminths
HIV	Human Immunodeficiency Virus	SUBEB	State Universal Education Boards
HKI	Helen Keller International	SWOT	Strengths, Weaknesses, Opportunities and Threats
HMIS	Health Management Information System	TB	Tuberculosis
HPI	Health Partners International	TIPAC	Tool for Integrated Planning and Costing
HSS	Health Systems Strengthening	TOR	Terms of Reference
IEC	Information, Education and Communication	UK	United Kingdom
ISS	Integrated Supportive Supervision	USAID	United States Agency for International Development
J&J	Johnson & Johnson	VFM	Value for Money
KAP	Knowledge, Attitudes and Practices	WaSH	Water, Sanitation and Hygiene
KII	Key Informant Interview	WHO	World Health Organization
LF	Lymphatic Filariasis		
LGA	Local Government Authority		
LLIN	Long Lasting Insecticidal Net		
LLP	Limited Liability Partnership		
LMIS	Logistics Management Information System		
LSHTM	London School of Hygiene & Tropical Medicine		
LSTM	Liverpool School of Tropical Medicine		
M&E	Monitoring and Evaluation		
MDA	Mass Drug Administration		
MITOSATH	Mission to Save the Helpless		

Executive Summary

Midterm review of the DFID funded Northern Nigeria Integrated NTD Control Programme (UNITED)

This is the mid-term review of a DFID funded four-year programme for the integrated control of Neglected Tropical Diseases (NTDs) in Northern Nigeria (UNITED). The programme is led by Sightsavers in consortium with Non-Governmental Development Organisations (NGDOs), academic partners, private sector partners and private sector suppliers. The main partners are Sightsavers, Helen Keller International (HKI), Christoffel Blindenmission (formerly) (CBM), Mission to Save the Helpless (MITOSATH), Crown Agents, Health Partners International (HPI) and Accenture Development Partners (ADP). The key stakeholders are the Federal Ministry of Health (FMOH) and the State Ministries of Health (SMOHs) in the five programme States.

The programme's goal is to reduce the prevalence and interrupt the transmission of seven NTDs that are amenable to preventive chemotherapy. Its aim is to strengthen the health system including drug supply chain management to deliver drugs to those in need. The programme is being implemented in the five states of Kaduna, Kano, Katsina, Niger and Zamfara.

The project comprises three phases:

1. Inception phase to set up programme management structures, process and complete disease mapping;
2. The integrated Mass Drug Administration (MDA) piloted in Zamfara State;
3. Expansion and scale –up of MDA programmes in Kano, Kaduna, Katsina and Niger.

The first three years are fully funded by DFID and it is expected that the State Governments will take over in year four.

The programme has five key activities:

1. Completion of mapping of NTDs in the five States (only in the inception phase)
2. Behaviour Change Communication (BCC)
3. Health System Strengthening (HSS)
4. Capacity building for supply chain management
5. MDA

The purpose of this evaluation is to:

- Assess the programme performance against milestones and other planned activities to ascertain if programme objectives are being met.
- Explore gaps in implementation and ensure corrective measures are put in place.
- Generate learning for DFID, Sightsavers, consortium members, government and other stakeholders.
- Assess benefits to the overall health system.

The evaluation questions are in the Terms of Reference in Appendix 5.

Methodology

A combination of quantitative and qualitative methods were used to address detailed evaluation questions around Sightsavers' standard criteria of relevance, effectiveness, efficiency, impact, scalability/replicability, sustainability and coherence/coordination. This involved a document review, a site visit to three of the five programme supported states (Zamfara, Katsina and Niger) and semi-structured key informant and focus group interviews. The information/data gathered was analysed using an evaluation framework based on the evaluation criteria (see Appendix 6) in order to robustly answer the evaluation questions and relate them to the five programme activities. Key informant information was triangulated in order to verify responses and develop constructive recommendations. Secondary data sources included project reports, logframes, M&E database, the project treatment database, project budgets and financial reports which were used to collate quantitative data for analysis.

Summary of main findings by programme activity

Mapping

UNITED fast-tracked the epidemiological surveys and mapping, it benefited from the Children's Investment Fund Foundation (CIFF) supported mapping of schistosomiasis and soil transmitted helminths (STH) in Katsina, Kaduna and Kano and the DFID funded Global Trachoma Mapping Project (GTMP). Schistosomiasis and STH mapping was also carried out in collaboration with the GTMP in Niger State. UNITED directly supported the mapping of Lymphatic Filariasis (LF) in Katsina. All mapping for the targeted diseases was completed by March 2014. Results of the mapping were used to plan the MDAs for the Local Government Authorities (LGAs) eligible for treatment. The mapping was also used to identify LGAs for baseline information for the planned impact assessment to look at the epidemiological impact of the programme. Changes in estimated disease prevalence were noted during the mapping exercise described above this underscores the need for up-to-date mapping to be carried out before MDA implementation, especially in places where other activities may have impacted NTD diseases prevalence e.g. through bed net distribution for malaria that could reduce transmission of LF or in WASH programmes impacting STH prevalence

Behaviour Change Communication (BCC)

The BCC component of the programme is led by HKI with input from other consortium partners. It involved a Knowledge, Attitude and Practice (KAP) survey in the pilot phase to identify effective communication channels for disseminating information and relevant community resources for influencing behaviour change around the five NTDs. The development of radio jingles was found to be of added value to the overall national NTD campaigns as well as for the UNITED Programme.

The BCC component requires strengthening. Levels of community sensitisation appeared to be low in the states visited. The monitoring and evaluation (M&E) plan articulated in the BCC strategy is not being implemented. The programme is not identifying gaps in implementation as planned and is not collecting the information set out in the BCC strategy. The project is relying on one consultant for monitoring

BCC activities for all MDA's in all states and all implementation levels. Overall, the documentation of BCC activities and plans within the project can be strengthened and there is currently no clear evidence of some key planned activities including the establishment of a BCC Committee at state level.

Health System Strengthening (HSS)

HSS to support the national health system to deliver NTD interventions in an effective, efficient and sustainable manner was achieved through technical support by Health Partners International (HPI), with some elements supported by Accenture Development Partners (ADP). The HSS component has played a key role in strengthening the health system for the MDA for NTDs and is achieving its goal to support a sustainable NTD control programme. Moreover, it has impacted positively on the broader health system, through uptake of some of UNITED's processes by other states and parts of the health system.

Capacity building for supply chain management

Crown Agents is leading this activity to strengthen health management information systems (HMIS) and drug supply chain management (SCM) by providing technical support to the Ministry of Health (MoH) at federal and state levels in the five states. Overall, the capacity building on drug supply chain management has been successful in achieving its objectives. The strengthening of SCM has improved drug accountability at state and LGA level and the Logistics Management Information System (LMIS) forms work well in drug tracking. Crown Agents is responsible for bringing drug supplies from the port to the LGA, and this removes bottlenecks previously experienced. The consultants were not able to talk to the FMOH regarding sustainability and integration of the delivery of NTD drugs into the existing system post DFID funding, but consortium members and KIIs at SMOH level raised this as a concern and we highlight this as something that needs to be followed up.

Mass Drug Administration (MDA)

The integrated MDA programmes in all five states have experienced external challenges but are being implemented successfully. The programme overall has reached 85% of annual targets. See Appendix 1 for the variances between state and between LGAs. Some states achieved the recommended therapeutic coverage for some diseases e.g. Kaduna achieved the coverage for two of four diseases, Kano and Niger achieved coverage for three of four diseases, Zamfara was border line for all two diseases treated and Katsina did not achieve any (Appendix 1, figure 7) although, there are variances in some LGAs that performed below target and some above target. Long term success of the MDA will depend on sustained funding at state level and although most state budgets have a budget line for NTDs, concern was raised regarding difficulty in release of these funds. Sustained impact will depend on community-based approaches that emphasise health protection and promotion with planning and targets that are understood, supported and agreed upon by the entire community, including local authorities. The importance of involving community and religious leaders from the outset was clear from Key Informant Interviews (KIIs) and community group discussions. A constant issue for the NTD MDAs generally (not just UNITED or Nigeria) is that of Community Drug Distributors (CDD) incentives. In the case of UNITED, not only is there a concern due to other programmes that use CDDs and pay them, but also that there are differences in how the UNITED consortium NGDO partners provide the transport

incentive and other incentives such as caps and T-shirts. It would be useful to collect lessons from the states and partners in order to develop a common approach.

Governance and Coordination








It is clear that there is a strong coordination structure in place. The consortium model is viewed as a key strength of the UNITED programme and the cross learning is being disseminated by partners to their non-UNITED supported programme states.

There is a strong framework for programme, financial and programme management, fostering an efficient and target oriented programme approach. The close working relationship between Sightsavers UK Finance and the Programme Management Office (PMO) appears to contribute to ensuring Value for Money (VFM) within the project. The operationalisation of a planned VFM dashboard will provide empirical evidence to the extent to which VFM is being achieved and provide an opportunity for learning across states and identify any potential areas for improvement. It is not possible at the time of this mid-term review to emit a judgement on the achievement of VFM.

State and consortium partners interviewed highlighted that a key strength of the UNITED programme lay in the consortium approach to the implementation of the programme. In particular, SMOHs were positive about how the UNITED programme provided access to support from a wide range of partners with specific technical expertise. HPI's efforts around HSS and Crown Agents support to SCM at the state level were particularly highlighted.

Evaluation Criteria

The agreed evaluation questions are rated in the report on page 37 to clarify what is working well and what is not working so well.

Evaluation Criteria	Rating	Comments
Relevance		<ul style="list-style-type: none"> - UNITED programme addresses control of PCT diseases consistent with Nigeria Master Plan for Neglected Tropical Diseases and State National NTD Plan based on KII interviews in Niger and Zamfara.
Effectiveness		<ul style="list-style-type: none"> - There is clear value in the consortium model. - Integration of MDA activities is evident at all levels and cost effectiveness through time saved through the joint planning and training activities. - New management processes are promoting effectiveness. - The rating is brought down by the BCC component which is the weakest area and the BCC strategy needs to be strengthened with a clear action plan for advocacy, communication and better utilisation of the influence of traditional leaders in the community as well as a stronger M&E to measure effect.
Efficiency		<ul style="list-style-type: none"> - Clear value in the consortium model but can be improved. - Integration of MDA activities is evident at all levels and efficiency through time saved through the joint planning and training activities. - New management processes are promoting efficiency - VFM through effective software, good training and strong relationship between UK, PMO office and regular audits - Systems are in development but the planned VFM dashboard is not yet operationalised. As this is year three of the programme, accelerating the operationalising of the dashboard will enable the programme to capture costs related to VFM and this is important
Impact		<ul style="list-style-type: none"> - There is clear evidence of the success of the HSS and strengthening of the Drug Supply Chain Management. - <i>Impact</i> of these cannot be seen at this point in the programme, hence the rating.
Sustainability		<ul style="list-style-type: none"> - Clear evidence of an exit strategy and a robust approach to a transition plan that looks at what can realistically be achieved in terms of funding from Government and where the gaps are, with planning to address these. - There are concerns on the sustainability of the transport of the drugs from the port to the LGAs, which is currently done by the UNITED programme directly.
Scalability / Replication		<ul style="list-style-type: none"> - There is evidence that process and strategies are in place to replicate and scale up programmes, but there is room for improvement
Coherence/ Coordination		<ul style="list-style-type: none"> - Overall, there is good coherence of the programme with the national and global context. Coordination between consortium partners and State and Federal MOH is good. Coordination with other stakeholders could be improved

Implications of the findings

The UNITED programme is demonstrating the value of a consortium model that brings in the skills of different partners to support overall HSS including drug SCM and implementation of integrated MDAs. However in order to be able to achieve the ambitious disease elimination targets (by 2020), the therapeutic coverage of the MDAs need to remain high and the programme is already going into its third year.

Implementation of an effective BCC strategy will be important for sustaining therapeutic coverage and adherence to treatments. The Federal and State Ministries of Health are expected to take full responsibility for the programmes in 2017 and in order to ensure sustainability, the work with the states on the transition plan and exit strategy needs to be accelerated.

Key Recommendations that emerged from the review

For the UNITED programme including the FMOH

1. Development and implementation of an advocacy and communication plan as a programme activity: high level advocacy is urgently needed for buy-in and commitment to the NTD programme at all levels of National and State MOH as well as with traditional and religious leaders.
2. Implement a continuous process of BCC over the course of the year, not just at MDA time
3. HKI (with input from other consortium members if needed) should support its staff in Katsina to build a stronger relationship with the SMOH.
4. Federal and State level should be encouraged to develop plans for advocacy and resource mobilisation for when UNITED funding ends (including from private sector).

For UNITED, FMOH and DFID

5. Plan for how the surveillance will be carried out for diseases where the threshold for treatment has been reached - operational and funding
6. Utilise opportunities to improve collaboration with other DFID funded health and development programmes in Nigeria (e.g. annual workshops involving all programmes).

Supply chain (UNITED, FMOH)

7. Ensure there are mechanisms to sustain the integrated drug storage system and integration into the national supply chain of the tools and process introduced by Crown Agents for the UNITED programme
8. Further Improve implementation of reverse logistics by identifying funding options and clarifying roles and responsibilities

Coordination/collaboration (UNITED, FMOH, SMOH)

9. Find ways to improve collaboration with other NGOs and organisations involved in school feeding for the schistosomiasis programmes, stronger collaboration with SUBEB and advocate that government strengthens these links
10. Adults as well as children in high risk communities will need to be included in annual MDA's as stipulated in WHO guidelines - all areas where baseline

prevalence of infection is 50% and above, in order to reach the programme milestone for schistosomiasis (caveat is that Praziquantal is donated only for school-aged children).

11. School-based activities are the responsibility of the Ministry of Education and the involvement of health workers in the planning and implementation of school based MDAs needs to be strengthened, particularly in the management of adverse events.

MDA (UNITED, FMOH, SMOH, DFID)

12. When potential or actual drug supply problems occur, act quickly and consider using high-level global stakeholders to help unblock the problem
13. Attention needs to be paid to CDD work load and actual numbers of people they are treating

BCC (UNITED)

14. The BCC/IEC component of the UNITED programme needs to be strengthened at all levels from the national to community level.
15. The M&E component of the BCC strategy needs to be reviewed and implemented in line with the BCC strategy in order to reach the project targets

Other Recommendations for UNITED to consider

UNITED programme, including the FMOH

1. Explore developing a minimum set of standard strategies for consortium partners for implementing MDAs (BCC, Logistics, CDD incentives, M&E)

Coordination/ collaboration (UNITED, FMOH, SMOH)

2. Explore how to work with organisations working on palliative/morbidity care for LF e.g. with the tuberculosis/leprosy programme, Leprosy Mission, handicap international etc.

MDA (UNITED, FMOH, SMOH)

3. As community and religious leaders will be critical in sustaining the MDAs, consider a specific, annual IEC programme for them.

M&E (UNITED, DFID)

4. Ensure a coherent M&E system that is aligned with the UNITED DFID logframe with quality assurance of M&E at PMO office e.g. ensure documents are dated, numerators and denominators are clearly defined within the document, and assumptions are clearly outlined.
5. Recommend a due diligence process to identify where consortium members are using different templates with a view to implementing standardised templates for the UNITED programme across the five States and implementing partners.

BCC

6. BCC monitoring should be built on existing routine monitoring systems

1. Introduction and Background

Purpose of the evaluation - UNITED Mid-term Review

This is the report of a mid-term review of the four-year, £11.6m United Kingdom (UK) Department for International Development (DFID) funded UNITED programme. The programme is being implemented in the five states of Kaduna, Kano, Katsina, Niger and Zamfara and targets communities endemic for onchocerciasis, lymphatic filariasis (LF), schistosomiasis, soil transmitted helminths (STH) and blinding trachoma.

The purpose of this evaluation is to:

- Assess programme performance against milestones and other planned activities to ascertain if programme objectives are being met
- Explore gaps in implementation and ensure corrective measures are put in place
- Generate learning for DFID, Sightsavers, consortium members, Government and other stakeholders
- Assess benefits to the overall health system

The review covers the period from the 1st of October 2013 to the 30th of September, 2015 and assesses programme performance against the milestones and targets against the programme objectives and across the five key activities. The team reviewed current implementation against experience from other major health and integrated NTD control programmes and looked for key learning, gaps in implementation and where the programme could be strengthened in order to achieve its objectives by the end of the programme in 2017.

The Neglected Tropical Diseases

The World Health Organisation (WHO) definition of NTDs includes 17 parasitic and bacterial infections¹, which can cause loss of livelihood, disfigurement, stigma, disability and poverty and lead to irreversible blindness, chronic illness, physical deformities and death. Globally, over 1 billion people are infected with one or more of the NTDs, of which approximately 500 million live in Africa. NTDs affect the poorest, hardest to reach people, who are often in remote or conflict zones, with minimal access to health services, which contribute to perpetuating conditions of poverty (Hotez, 2006; Hotez, 2009). Women and children are disproportionately affected by some NTDs, for example adult women represent 70% of the trichiasis burden and are more than twice as likely to be afflicted in comparison to men (Carter Center, 2009), whilst schistosomiasis and STHs primarily affect children.

This group of diseases has been termed as 'neglected' for several reasons:

- i) many are relatively asymptomatic for a long time,
- ii) the association of death with an NTD is not recognized

¹ Buruli Ulcer, Chagas disease(American trypanosomiasis), Cysticercoids/Taeniasis, Dengue/Severe dengue, Dracunculiasis (guinea-worm disease), Echinococcosis, Fascioliasis, Human African trypanosomiasis, Leishmaniasis, Leprosy, Lymphatic filariasis, Onchocerciasis, Rabies, Schistosomiasis, Soil transmitted helminthiasis, Trachoma, Yaws

- iii) recent emphasis and resources spent on “the big three diseases” of HIV, malaria and tuberculosis meant that endemic countries did not receive appropriate support to tackle the NTDs
- iv) NTDs have not been commercially interesting for pharmaceutical companies.

As a result, until recent times NTDs were not seen as a priority by the affected communities, the national authorities or the donors.

The seven NTDs outlined below can be effectively treated through mass drug administration (MDA) to affected communities once or twice a year with drugs that are currently donated (in whole or in part) by pharmaceutical companies. This is termed preventative chemotherapy (PCT) and includes:

- Blinding trachoma (azithromycin – Pfizer)
- Schistosomiasis (praziquantal- Merck KGA)
- Lymphatic filariasis (LF) (ivermectin- Merck/ albendazole- GSK)
- Onchocerciasis / river blindness (ivermectin- Merck)
- Soil Transmitted Helminths (STH) - hookworm, roundworm, whipworm (mebendazole – J&J/ albendazole- GSK/ ivermectin- Merck)

Global context

The MDA programmes for onchocerciasis, LF and STH have expanded throughout Africa over the last decade, and since 2006 there have been efforts to integrate NTD control programmes in order to maximise impact, efficiencies and cost-effectiveness. In January 2012, WHO published an ambitious “*Roadmap for Implementation*”, this document sets out implementation targets for the control, elimination, or eradication of 17 NTDs by 2020.

Following the publication of the WHO NTD Roadmap, “*The London Declaration on NTDs*” was announced on January 30th 2012, after several prominent leaders in global health and development organisations and industry partners met in London and pledged to unite their efforts to support achievement of the WHO 2020 targets with respect to the NTDs manageable through MDAs. A coalition of partners called “Uniting to Combat NTDs” was also established to provide support towards attaining the WHO Roadmap targets for 10 of these NTDs^{2 3}.

Key pillars of the London Declaration on NTDs and Uniting to Combat NTDs were pledges to:

- Jointly support the control, elimination or eradication of the 10 NTDs
- Enhance collaboration and coordination on NTDs at national and international levels through public and private multilateral organizations in the NTD community and other relevant sectors, such as water, sanitation, and hygiene, and education (WASH);

² Chagas disease, Guinea worm disease, human African trypanosomiasis, leprosy, lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminths, trachoma, and visceral leishmaniasis.

³ www.unitingtocombatntds.org

- Report regularly on the fulfilment of commitments by partners, as well as tracking key milestones towards the WHO 2020 targets.

In the UK, DFID was one of the original endorsers of the London Declaration and announced a commitment of £195 million through to 2015, targeted at guinea worm, LF, river blindness and schistosomiasis, as well as the development of new programmes for blinding trachoma, visceral leishmaniasis, research and integrated country approaches.

It is important to note that although the primary *prevention* for infection with five of the ten NTDs in the London Declaration should rely on improved WASH, to date, NTD control initiatives have relied predominantly on MDA. Studies have however, shown continued re-infection post-PCT where WASH interventions were not part of the strategy (WASHplus, 2014). To address this issue, WHO has recently developed guidelines targeting national programmes and partners for implementing NTD control programmes in collaboration with the WASH sector.

Nigeria context

Nigeria has the highest number of people with NTD infections in Africa and it is estimated that over 100 million people (two of every three Nigerians) suffer or are at risk from one or more of these diseases. All the PCT- targeted NTDs are endemic in Nigeria, and every LGA in the 36 States has at least one or two PCT NTDs. Other NTDS such as dengue, yaws, human African sleeping sickness and buruli ulcer are focally endemic.

Nigeria has the highest number of cases globally of onchocerciasis and schistosomiasis, and the third highest endemicity for elephantiasis. Onchocerciasis community directed treatment with ivermectin (CDTI) has been implemented in Nigeria since 1996 (supported by the African programme for Onchocerciasis Control - APOC) and has built strong CDTI platforms in onchocerciasis-endemic States. NTD programmes have also been established in Nigeria - but these have been more vertical with only a few integrated NTD programmes being established in some states e.g. the RTI –Envision⁴ NTD programme. Nigeria has made substantial progress in the elimination of some of the NTDs and in December 2013, Nigeria was certified free from indigenous transmission of guinea worm disease (GWD). National elimination levels have been attained for leprosy, although sub-national elimination levels have not yet been reached.

In view of the high burden of NTDs in Nigeria, a national NTD Policy was developed in 2010 and updated in 2014, which promotes coordination of control and elimination efforts for NTDs and advocates for expansion of treatment programmes throughout the country. This national policy on NTDs provides guidelines which address integrated approaches to planning, coordination, and resource mobilisation, interventions on NTDs, disease surveillance, supervision, monitoring, evaluation and research. The roles of the various partners and stakeholders are also defined. The multi-year National NTD Master Plan (2013-2017) which describes operational mechanisms for integration of NTD interventions in Nigeria was launched in

⁴ ENVISION supports the NTD programme in Nigeria at the federal level and in 9 states (Anambra, Abia, Edo, Delta, Imo, Enugu, and Ebonyi, Plateau and Nassarawa)

February 2013 and updated in May 2015 for 2015 - 2020 and is set within the framework of the National Health Policy.

UNITED: An integrated programme approach to control NTDs in Northern Nigeria

As a key player in the control and prevention of NTDs, one of the initiatives announced by the UK at the London Declaration on NTDs was an integrated programme approach to tackle NTDs in two countries in order to reduce the global burden of NTDs.

Considering the NTD burden in the country, DFID, UK selected Nigeria for support of integrated control of NTDs through a four-year programme (October 2013 - September 2017) in Northern Nigeria, called UNITED. This programme is being implemented by a Sightsavers-led consortium of NGOs, academic partners, private sector partners and private sector suppliers. The main partners are Sightsavers, Helen Keller International (HKI), Christian Blind Mission (CBM), Mission to save the Helpless (MITOSATH), Crown Agents, Health Partners International (HPI) and Accenture Development Partners (ADP).

Project geographical scope

The initial project support was to Kano, Katsina, and Zamfara States; however, the lower-than estimated prevalence of the diseases in the three states resulted in a contract amendment in 2014 to extend the programme to Niger and Kaduna which already had existing CDTI platforms thus, requiring minimal expansion to scale-up for treatments for schistosomiasis, STH and blinding trachoma in order to increase coverage.

UNITED goals, activities and objectives

The overall goal of UNITED is to reduce the prevalence and interrupt the transmission of seven NTDs that are amenable to preventive chemotherapy. The programme aims to strengthen the health system including drug supply chain management to deliver drugs to those in need.

There were eight programme objectives and five resulting key activities at the outset⁵ as detailed below:

Programme Objectives

- To operate MDA at scale in Zamfara (and continue existing NTD programmes in Kano, Katsina, Kaduna, and Niger States).
- To operate integrated MDA at scale in Zamfara, Kaduna, Kano, Katsina and Niger (and continue existing programme in Jigawa)
- To set up processes to gather evidence for decision making (including support mechanisms to strengthen the HMIS).
- To deliver a range of health system strengthening technical support to the MoH at federal and state levels in Kaduna, Kano, Katsina, Niger and Zamfara (including drug SCM).

⁵ the mapping activity was completed at the end of the inception phase and was dropped from the activities and logframe

- To support effective BCC/Information, Education and Communication (IEC) campaigns in the five states of Zamfara, Kano, Katsina, Kaduna and Niger.
- To improve coordination with all relevant stakeholders in the five states.
- To improve evidence for decision making (including support mechanisms to strengthen the HMIS)
- To deliver a robust management approach from the Programme Management Office (PMO) driving economy throughout the programme cycle

Programme Activities

1. Mapping of NTDs
2. BCC and coordination
3. HSS
4. Capacity building for drug supply chain management
5. MDA

The Programme is implemented in three phases:

- Phase 1 - Inception Phase, October 2013- December 2013
- Phase 2 - Pilot Phase, integrated MDA piloted in Zamfara, October 2013- September 2014
- Phase 3 - MDA scaled up in four additional States of Kano, Katsina, September 2014: then Niger and Kaduna May 2015

The final handover phase will take place in year four, 2016, when the FMOH and SMOH are to take full responsibility for the programme in the five states.

2. Methodology

The review took place between November 2015 and January 2016, including a visit by the consultants to Nigeria during the first two weeks of December 2015. Appendix 5 gives the full details of the Terms of Reference for the evaluation.

Following the WHO recommended methodology for evaluation of NTD control programmes at country level (WHO 2008), a combination of quantitative and qualitative methods were used to address a comprehensive set of questions (see section 3.7) around a set of standard criteria including Relevance, Effectiveness, Efficiency, Impact, Sustainability, Scalability/replication and Coherence/coordination.

Document review

Documentation was reviewed at the inception, data collection and analysis stages to gain insight into programme's progress; identify respondents for KIIs and focus group discussions (FGDs); inform the development of evaluation tools; and support the analysis of data from the KIIs and FGDs. Additional documents were sourced through online searches for relevant global and national policies and strategies. The list of documents reviewed is given in Appendix 2.

Quantitative data collection

Secondary data sources such as project reports, logframes, M&E database, the project treatment database, project budgets and financial reports, were used to collate quantitative data for analysis. Appendix 1 presents an analysis of project

achievements against targets by project outputs as articulated in the logframe date 30th October 2015.

Qualitative data collection

A combination of semi-structured KIIs and FGDs was used to gather qualitative data. Interviewees were purposefully selected to represent the diverse range of perspectives required to robustly answer the evaluation questions. Identification of potential interviewees was made in consultation with Sightsavers during the inception phase. Appendix 3 is the list of interviewees by category. In total, interviews were carried out with 53 interviewees from four categories (consortium members, SMOH, FMOH, pharmaceutical company). As far as possible, KIIs were face-to-face, however, some interviews were conducted by phone.

In order to cover the number of interviews required and the distances to be covered, the review team split up to visit three programme supported states (Katsina, Niger and Zamfara) and Abuja.

Eight FGDs were carried out with CDDs, front line health workers and community members in a mix of urban and rural populations in Katsina, Niger and Zamfara. Selection of areas for these FGDs was done in consultation with Sightsavers based on: 1) a well-performing MDA programme; and 2) an MDA programme that did not perform (as) well, based on programme treatment data. Practical considerations such as access to the community also informed selection of the location for the FGDs. Although, FGDs usually comprises 8-10 participants, these FGDs attracted a larger number of participants and were split between males and females.

Appendix 4 gives an example of the KII and FGDs interview guide. These were modified and adapted during the data collection process.

Data Analysis

Quantitative data analysis:

Key project quantitative data collected was entered into an Excel database developed for this review. Data was analysed providing numerical summaries of project progress against set targets and plans, looking for demonstrated project impact taking into account any discernible trends. Comparisons between supported states where relevant and feasible have been done.

Qualitative data analysis:

Qualitative data from the interviews was analysed by the consultants at the end of each day using thematic analysis based on the evaluation criteria. Responses were assigned to an evaluation framework tool developed from the evaluation criteria. The consultants' team jointly developed summaries, conclusions and recommendations from the preliminary findings. Throughout the data analysis, the team sought to identify factors that contribute to programme's success and provide actionable recommendations.

SWOT analysis

A strengths, weaknesses, opportunities and threats (SWOT) analysis of the programme and partnership was developed based on responses from the KIIs and

FGDs, supported by triangulation of information obtained and document review. Results were used to inform the review team's debriefing with the Sightsavers team before departure from Nigeria.

Evaluation Matrix

The review team ensured that the detailed evaluation questions were investigated in light of the objectives set out in the review ToRs. The evaluation questions were applied to the five key project specific activities: Mapping, BCC, HSS, capacity building for drug supply chain management and MDA. Coordination was originally included in the BCC component, but as coordination and governance were seen as a cross-cutting, and in order to capture efficiency and value for money (VFM), a sixth element was added and reviewed using the evaluation questions relevant to these areas.

Answers to all evaluation questions are summarised in an evaluation matrix that can be found in section 3.7. Each question was in addition rated using the Sightsavers pre-defined rating scale. In order to avoid potential bias, rating was done following a three-step process: firstly, each reviewer gave a rating for the evaluation questions; secondly, if the three reviewers rating did not correspond, the team reviewed together the evidence in support of the question before agreeing a final rating. Finally, during the debriefing in Nigeria, the PMO team was given the opportunity to provide additional insight/evidence in support of ratings they perceived should be different. The reviewers then reviewed the additional evidence, discussed and agreed a final rating for the relevant question.

Limitations

A number of limitations were encountered in the execution of this review. Firstly, a number of key perspectives are not included in the qualitative data as the review team was unable to meet some KIIIs (WHO-NTD, USAID, and senior members of the Federal Ministry of Health) for a number of reasons including feasibility, availability and inability to participate in the review.

Secondly, the review called for analysis on key cost drivers of the programme as well as insights into matters to do with cost effectiveness. However, during the course of the review, it was clear that it was not feasible to carry out a robust cost effectiveness analysis in the timeframe of the review. Furthermore, the programme is in the process of rolling out a number of initiatives that will further address these aspects of the programme including a methodology for carrying out a cost effectiveness analysis within the UNITED programme to inform/assess related cost effectiveness targets and the rolling out of a VFM dashboard to assess the key cost drivers within the programme.

3. Results

The results section begins by summarising the performance and achievements for each of the five key programme activities, to which a sixth component of Governance and Coordination has been added. Specific recommendations are given for each activity. These summaries are followed by the evaluation matrix and rating of the seven evaluation criteria and key evaluation questions to give a comprehensive view of programme performance. The section ends with the presentation of the team's SWOT analysis of the programme.

Programme Activities

3.1 Mapping

To determine which LGAs were eligible for MDA, mapping of the disease prevalence was necessary. The NTD mapping was completed in Zamfara before the start of the UNITED project. However, prevalence data for Katsina and Kano from the Federal MoH (FMOH) needed updating.

The objective of this activity was to complete the mapping of NTDs in the targeted states during the inception phase. Mapping was supported by Sightsavers and was in collaboration with USAID and the Children's Investment Fund (CIFF).

Findings, achievements and areas for strengthening

UNITED was able to fast-track the epidemiological surveys and mapping through collaboration with USAID and CIFF for schistosomiasis and STH in Katsina and Kano and the DFID funded Global Trachoma Mapping Project. UNITED directly supported mapping of LF in Katsina, and mapping of all LGAs in Kano and Katsina for the targeted diseases, this was completed by March 2014.

Results of the mapping were used by the programme to plan the MDAs for the LGAs eligible for treatment. The mapping in Kano and Katsina revealed fewer LGAs qualified for MDA for trachoma, LF, schistosomiasis and STH than originally estimated and discussion with DFID allowed the programme to expand to Niger and scale-up in Kaduna State. This underscores the need for mapping prior to MDA, especially where other activities may have impacted NTD disease prevalence for example, CDTI with ivermectin/albendazole for onchocerciasis and LF and long lasting insecticidal net (LLIN) distribution.

The mapping identified LGAs for the impact assessment to determine changes in disease prevalence resulting from the programme and as baseline information for determination of epidemiological impact of the programme. Following WHO guidelines, the FMOH will be responsible for organising the impact studies with national universities after three and five years of MDA. Currently, there is a funding gap for impact studies and surveillance once the threshold for MDA has been achieved.

Logframe indicator for mapping from annual report to DFID 2014:

Indicator(s)	Milestones		Progress	
	Date	Target	Date	Actual
Number of LGAs completely mapped for all diseases in targeted states	Sept 2014	78 (44 LGAs Kano + 34 LGAs Katsina)	Nov 2014	78 (100% of target)

Conclusions

The mapping activity was successfully completed and the results have been used effectively for strategic planning.

Recommendations

Going forward, it will be important to ensure that planning for impact studies is on course and gaps in funding for the impact assessment studies are being addressed.

3.2 Behaviour Change Communication

The BCC component of the programme is led by HKI with input from other consortium partners (based on geographic and technical comparative advantage).

BCC/IEC is viewed as a critical aspect for achieving the programme objectives by fostering long term health behaviour change, increased beneficiary active involvement and service uptake, government ownership and sustained support to programme achievements. Although it is clear that advocacy and BCC activities are part of the National NTD policy and included in the master plan, it appears that funding for these activities has been limited. However, the FMOH is clear in its intent for development of BCC materials to be harmonised for use in sensitising and mobilising stakeholders.

The programme BCC strategy is built on the five components (below) with the programme objective of supporting effective BCC campaigns in the five states.

1. Development and implementation of a strategic framework to identify and prioritise key NTD issues in need of BCC intervention.
2. Identification of solutions to address key issues and solve identified knowledge, attitude, behaviour and practice issues and/or problems.
3. Correction of misconceptions regarding diseases and treatments and identification of channels of communication.
4. Development of BCC implementation and action plans.
5. Monitoring and evaluation of the BCC strategy to support prevention, treatment and stopping of disease transmission and eventual elimination of the five prioritised NTDs in UNITED consortium states.

Findings, achievements and areas for strengthening

The project commissioned a KAP survey in Zamfara and Katsina in 2014 in order to inform the development of the programme BCC strategy and IEC materials to support the MDAs.

Based on the results of the KAP survey, a robust BCC strategy intended to provide a comprehensive roadmap for supporting the programme, including a strong M&E framework was developed. In practice, BCC activities appear to be concentrated round MDA. Interviewees expressed the need for ongoing communication around the five diseases, with BCC activities being intensified during the MDAs. The validity of this suggestion was confirmed during the consultant's site visits as some front line health workers (FLHW), CDDs, teachers and most communities visited displayed limited knowledge of the transmission and prevention of NTDs. Responses were often related to the prevention of malaria and guinea worm.

Radio jingles were developed in consultation with the FMOH and SMOH Health Education Units, NTD teams, representatives from NGOs and key members of the community. As of September 2015, the number of people reached during the MDAs with BCC/IEC NTD materials through radio jingles is estimated at 23 million. The jingles were aired on radio stations that cover between 80%-100%⁶ of the state's population. The IEC print materials were developed, translated, tested and disseminated for use in all programme states during MDAs. Key informants at the SMOH and LGA levels reported that the development of the radio jingles and IEC materials for the programme has added value to the overall national NTD IEC campaigns and identified these as the main components of the BCC strategy.

Community mobilisation activities should be an integral part of the MDA interventions. However, in Katsina, where there was no existing CDTI platform and MDAs were implemented for the first time, community sensitisation appeared to be weak. CDDs in Katsina highlighted the absence of identification materials (caps, t-shirts etc.) as having a negative impact on the programme's visibility in the community and the CDD's motivation. In addition some interviewees at the LGA level highlighted the need for strengthening the use of the influence of traditional leaders in the community in improving MDA uptake particularly in states where NTD programming is new.

Monitoring the implementation of the BCC is one of the key components of the BCC strategy. To this end, a consultant was hired in July 2015 by UNITED to assess the status of BCC activities in the programme states. The consultant and a programme assistant from HKI were tasked with the 'in-process' monitoring of the implementation of BCC activities during MDAs which was aimed at ascertaining the quality of the implementation of BCC activities as well as gauging the level of knowledge of the relevant community members.

The M&E plan as articulated in the BCC strategy is not currently being implemented. For example the BCC strategy⁷ sets out over 60 process and impact indicators for measurement as part of routine monitoring and project impact evaluation but there is no evidence of a BCC M&E protocol to collect the indicators set out in the strategy. To date the project appears to be relying on using a single consultant to monitor BCC activities during the MDAs in all states and at all implementation levels. The current M&E approach is not suitable for identifying gaps in implementation and is not sufficient to collect the information set out in the BCC strategy.

⁶ based on experience from other health programme use of radio stations

⁷ Behaviour Change Communication Strategy Document and Strategic Framework for 5 Neglected Tropical Diseases (NTDS) – Document undated – pdf created on 30th October 2015.

This review also highlighted the absence of a high level advocacy and communication strategy involving a high profile individual to carry out advocacy visits to state governors with the aim of improving state ownership of the NTD programming. While such a plan was in development, a number of external factors (such as national elections) had stalled it.

Logframe indicator for BCC (from draft annual report to DFID 2015)

Indicator(s)	Milestones		Progress	
	Date	Target	Date	Actual
Number of people reached with BCC/IEC NTD messages through radio jingles	Sept 2015	23 m	Sept 2015	23m ⁸ (100% of target)

Conclusion

Although the milestone for this activity was achieved, the BCC/IEC component of the UNITED programme needs to be strengthened at all levels i.e. from the national to community level. The M&E component of the BCC strategy needs to be reviewed and implemented in line with the BCC strategy if the project targets are to be achieved.

Recommendations

- A high-level advocacy plan for the five programme states needs to be finalised and implemented and to maximise effectiveness, collaboration with the RTI-Envision NTD programmes and the National NTD programme should be included as part of this plan.
- Overall documentation of BCC activities and plans within the project could be strengthened as there was no clear evidence of some key activities, including the establishment of a BCC committee at state level.
- Strengthen support to FMOH in developing and implementing a National NTD BCC strategy based on lessons learned from the UNITED programme.
- The BCC strategy should be updated to take into account issues specific to the two states included in the programme since its development. For example, a strategy for translation of IEC and radio jingles in Niger state where Hausa is not as widely spoken as in other states.
- In states new to MDA for NTD, use of IEC materials such as t-shirts and caps during MDAs would enhance programme visibility and CDD motivation.
- The strong influence of traditional rulers and other community based structures should be harnessed to improve uptake and knowledge of the programme in implementation states.
- An appropriate BCC M&E protocol needs to be developed to adequately monitor the implementation of the programme BCC activities, identify and address gaps and capture the indicators articulated in the BCC strategy. It is also recommended to review the feasibility of measuring the 60 planned indicators⁹

⁸ The number of people reached with radio jingles was calculated based on information from other health programmes' use of the same radio stations and estimated at 80% of the state population

⁹ Behaviour Change Communication Strategy Document and Strategic Framework for 5 Neglected Tropical Diseases (NTDS). Document undated – pdf created on 30th October 2015.

3.3 Health Systems Strengthening

Although the drugs are free, MDA programmes can take a considerable toll on the capacity and resources of the health system. As MDAs for different NTDs can be achieved through similar strategies and means, an integrated approach can yield significant cost savings in areas where several diseases co-exist. To be successful, integrated NTD control should be supported by training and strengthening of all levels of health staff and community volunteers involved in the programme. A strong public health system is a prerequisite for the success of MDA programmes and strengthening the national health system is critical. In Nigeria, the FMOH is responsible for policy formulation, coordination and impact assessment of the NTD programme. The NTD programme's implementation in the States is the responsibility of the SMOH, with the national NTD steering and secretariat committees providing technical advice to the national NTD programmes.

The UNITED programme objectives specifically relate to this activity to deliver a range of HSS technical support to the FMOH and SMOH in Kaduna, Kano, Katsina, Niger and Zamfara.

Findings, achievements and areas for strengthening

The UNITED consortium, through technical support by HPI (with some elements supported by ADP) has been working to strengthen the national health system with the aim of delivering NTD interventions in an effective, efficient and sustainable approach. Discussions with national and NGDO stakeholders confirmed that the HSS through UNITED is playing a key role in strengthening the health system for the MDA for NTDs. For example, KIs reported that capacity building for programme management, coordination and computer training was useful for participants in all aspects of their work, not just for the NTD work. All KIs at state and LGA level reported that the development of NTD cadre staff job descriptions at both levels has strengthened capacity through realising clearly delineated roles and responsibilities. This is leading to better NTD coordination and management as well as promoting programme ownership. Evidence of impact on the broader health system was shown by FMOH and SMOH personnel from several other health programmes and states participating in UNITED facilitated workshops on identifying NTD indicators for inclusion in the Integrated Supportive Supervision (ISS).

Some of the other achievements are outlined below:

- Training of NTD teams and support to FMOH and SMOH in carrying out joint baseline assessment of health systems in order to determine staffing and training needs before integrating NTD operations.
- Support to the FMOH and SMOH in review and alignment of national and state NTD master plans with the Global 2020 NTD elimination targets.
- Facilitating establishment of State NTD task forces with the aim of strengthening NTD coordination and implementation at state level.
- Inclusion of NTDs in the 2010-2015 national strategic health development plan (NHSDP) and inclusion of NTD indicators in the ISS schemes at state level.
- In collaboration with RTI-ENVISION, training of zonal M&E officers for efficient monitoring of NTD activities in UNITED supported states and training of NTD coordinators on Tool for Integrated Planning and Costing (TIPAC)

The support to the FMOH and SMOH in the five states to develop plans for transitioning the programme to national and state authorities leadership by year four is critical and this process and implementation of the exit strategy needs to be accelerated as the UNITED programme is already going into its third year and by the end of 2016, there will be no external funding from DFID. Failure to release budgeted funds at state level is the highest risk affecting the UNITED exit strategy. Although the Government is already contributing to the salaries of NTD staff, office space and in some cases vehicles, motor cycles or bicycles, to date, getting states to actually release funds does not seem to have happened¹⁰.

For long term impact, inter-sectoral collaboration will be important but, other than the Ministry of Education, collaboration with other line ministries such as Information and Agriculture, Water Supply and Environment, is still either minimal or lacking and this threatens programme sustainability. Inter-sectoral collaboration is vital to maximise the use of resources and ensure uniformity of implementation standards.

Logframe indicators for HSS from draft annual report to DFID 2015

Indicator(s)	Milestones		Progress	
	Date	Target	Date	Target
No. States with minuted NTD task force meetings with frequency of at least twice a year	Sept 2015	3	Sept 2015	2 (66% of target)
No. States with annual MDA reports written by State NTD team issued 90 days after completion of MDA	Sept 2015	5	Sept 2015	N/A Data collection in progress
No. States with NTD indicators integrated in the ISS tool	Sept 2015	3	Sept 2015	5 (166% of target)
% of national NTD steering committee meetings supported	Sept 2015	50%	Sept 2015	50% (100% of target)

Conclusions

As most of the milestones for the process indicators for the HSS activities were achieved in 2014 and 2015, apart from the release of State NTD Fund, overall this component has been successful in delivering HSS technical support to the public health system to support a sustainable NTD control programme. There are clear inputs and outputs and the support and the outcomes are very much appreciated at all levels, however, long term impact of the HSS will be best assessed at the end of the programme.

Recommendations

- The work on the transition strategy and exit plan needs to be accelerated as it is important to consolidate the transitional needs, roles and responsibilities for partners, the FMOH and SMOH in a clear action plan.
- UNITED needs to implement high-level advocacy in order to ensure that the Government will create budget lines and honour appropriate financial commitments for the NTD programme as well as releasing the funds allocated for NTD programmes.

¹⁰ The reviewers were not given any actual figures for State NTD budgets

- Further explore the role of private sector partnerships within Nigeria and outside of the programme's consortium, to support NTD implementation in the exit strategy.
- Together with other stakeholders, strengthen support to operational research which is necessary to address challenges in NTD programme implementation not only in early phases but also as the programme evolves
- Improve inter-sectoral collaboration with other ministries for broader health benefits and impact of the NTD programme.
- There is a need to explore how UNITED can collaborate or link-up with stakeholders implementing integrated vector management, which is a critical element in the national NTD control policy, for future sustainability of NTD control.
- There is a need to improve collaboration with and between organisations carrying out morbidity management due to NTDs e.g. hydrocoele surgeries and lymphoedema.
- The use of mobile phones for capturing of treatment data is a positive innovation. However, though reported in documents and interviews, the pilot in Zamfara did not work as well as expected due to several documented challenges. Review of other countries/programmes that have successfully implemented mobile phone technology in similar circumstances (e.g. Rwanda) could help revise the strategy.
- Review and support FMOH in finding ways to improve funding for ISS as it is inadequately funded, irregular and its funding is still partner driven.
- Involve the National NTD steering committee in addressing cross border surveillance collaboration with neighbouring countries, which is recommended in the national policy of NTD control. This activity is not supported under the UNITED programme although some of the five states do border other countries and it is important to collaborate with neighbouring countries in NTD control, especially where nomads or migrant workers may be involved.

3.4 Capacity building for supply chain management

Efficient and effective supply-chain management (SCM) plays a critical role in ensuring that NTD medicines are not only available for the communities that need them but also in a time for the optimum distribution period for the specific diseases. There are several potential challenges and complications in ensuring a cost-effective supply chain for the NTD drugs.

These drugs are procured through the three different mechanisms used by the pharmaceutical companies for drug donation and not directly from the pharmaceutical companies or their distributors as is the case for most essential drugs. Pfizer and Merck USA have their own processes for donation and shipment. Pfizer operates through the 'International Trachoma Initiative' while Merck USA use the 'Mectizan Donation Programme'. Donations from Merck KGA, J&J and GSK go through WHO which use a regional review panel to evaluate requests before passing the orders on to the respective manufacturing companies.

The NTDs are treated using a campaign approach unlike most other disease control programmes an exception is the polio vaccination campaign. There was a system in place for procurement and delivery of the NTD drugs for the MDA programmes

implemented by the NGOs before the programme was established but the supply chain was weak and inefficiencies had been identified.

Crown Agents already had an established role in the procurement of Praziquantal and other commodities for DFID-funded programmes as well as extensive experience in Nigeria and working with the FMOH and SMOH, and they were selected to lead this activity for the UNITED consortium. The objective for this activity was to build capacity for drug supply chain management

Findings, achievements and areas for strengthening

An assessment of the NTD drug supply chain was conducted by Crown Agents in order to identify bottlenecks and determine the best critical path for improved SCM. Weaknesses identified included, lack of defined distribution plans; no inventory management or tracking tools for the commodities stored, received or issued from the various medical stores; no monitoring and supportive supervision mechanisms and delays in drug clearance and transfer to the states that impeded rapid scale up of the MDA programme.

The capacity building carried out by Crown Agents, has been effective in several critical areas and according to those interviewed, it is highly appreciated by the FMOH, SMOH and NGO partners. The SCM training protocols of the joint planning and training sessions have been revised to incorporate lessons and experiences from each joint training exercise to make it more participatory and suitable for the different skill levels.

Key informants all commented on how Crown Agents strengthening of SCM has improved drug accountability at state and LGA level and that the LMIS forms help them track the drugs. The SMOH staff appreciated that Crown Agents is responsible for bringing the drugs from the port to the LGA, which removes one of the bottlenecks experienced before when the SMOH staff had to find a way to go and collect the drugs from the FMOH stores. However, this seems to be the least sustainable, if most appreciated, element of the drug SCM. Although most KIIs thought that there would be a way to ensure delivery of the drugs to the LGAS, there was little evidence of any concrete strategies being developed.

One of the other remaining weak areas is that of “reverse logistics”, the return of unused drugs to the state medical stores. This was designed as a shared responsibility but this was not a clear process in terms of roles and lacked funding. Crown Agents and some KIIs at SMOH level, highlighted that reverse logistics remains a challenge. Crown Agents have now designed a transfer form for stock to be retrieved from the community through the health facility and the LGA back to the State Central Medical Stores. However, for effective implementation of the reverse logistics, clarification of roles and responsibilities and clear funding stream needs to be identified.

The review team found a lack of clarity regarding the drug quantification processes and capacity for NTD drug quantification at state and federal level. In at least one state (Katsina) it was evident that SMOH was unaware of the details of how quantification was carried out. In Katsina, when the state NTD coordinator was

asked how quantification was carried out, the answer was “the NGO does it”. In Zamfara, the response was “from a Sightsavers survey”.

There were delays in arrival of drugs for the MDA which were due to both external and some programme related reasons. The late arrival of Zithromax in the country and subsequent problems due to the suspension of the duty and customs waiver for drugs has resulted in less than optimal MDA for trachoma and may impact 2016 MDAs if the issue is not resolved soon.

The key achievements in this area include:

- Training all stakeholders on aspects of supply chain management – drug quantification; correct storage; inventory management; reverse logistics and reporting.
- Creation of training and reference materials with key supply chain messaging for the different levels (State NTD Coordinators, FLHWs, CDDs) that are being incorporated into the national NTD control programme training resources.
- Development of guidelines and reference materials on NTD drug management and on planning and budgeting for the delivery of drugs for MDA.
- Development of a LMIS and tools for tracking, stock keeping, and transaction records of all NTD drugs that are being used by NTD programmes including those outside of UNITED.
- Strengthening NTD programme district-to-central-level accountability to improve feedback and performance for MDA.
- Improved performance and motivation related to drug supply chain at the State, LGA and health-facility levels.
- Introduction of on-the-job training, supportive supervision and monitoring for drug supply chain at LGA level.

Logframe indicators for SCM from draft annual report to DFID 2015

Indicator(s)	Milestones		Progress	
	Date	Target	Date	Actual
% of shipment of donated drugs that reach all eligible LGAs within 4 weeks of arrival in country	Sep 2015	60%	Sep 2015	65% (108% of target)
No. of States and LGAs in which drug SCM systems are effective based on accurate transcription records: receipt issue and retrieval	Sept 2015	3	Sept 2015	5 (166% of target)

Conclusion

Overall, the capacity building on drug supply chain management has been successful in achieving its objectives.

Recommendations

The review did highlight some areas that need improving or strengthening:

- Further Improve implementation of reverse logistics by identifying funding options and clarifying roles and responsibilities during and after the UNITED Programme.

- Active strategic and financial planning for the transport of the NTD drugs from the port to the LGA when the DFID funding to Crown Agents finishes.
- In the case of serious problems with drug procurement, delivery or clearance, consider mechanisms to work with the NTD Supply Chain Forum (Uniting to Combat NTDs), DFID and /or other major donors to help in resolving problems.

3.5 Mass Drug Administration (MDA)

MDA involves administration of safe, single-dose drugs to entire populations in order to control, prevent, treat or eliminate LF, onchocerciasis, schistosomiasis, STH and trachoma. The drugs are donated (or in the case of praziquantal, partly donated) by the pharmaceutical companies through three different mechanisms.

The expected success of the MDA is based on the assumption that once the prevalence of infection is reduced to below a critical threshold level, transmission will remain low and re-emergence of the disease as a public health problem is unlikely. When this point is reached, the MDA programmes will move from annual treatments to two yearly treatments and then towards disease surveillance. Although, MDA is the cornerstone of the NTD control programmes, it is pertinent to note that additional measures, such as vector control, improved hygiene and environmental sanitation and health education and information will be required in order for the impact to be sustainable. Furthermore, it is clear that appropriate health education delivered during the early stages of the MDA programmes and stimulation of community participation appear to be essential prerequisites for optimal coverage and success of the MDA programmes in terms of disease reduction and achieving disease elimination criteria.

All the implementing NGDO partners in this consortium have many years of experience in supporting MDA through a CDT platform for onchocerciasis and LF in several endemic States in Nigeria as well as close working relationships.

Findings, achievements and areas for strengthening

The MDA approaches designed and implemented by the UNITED programme are following the internationally recognised WHO treatment guidelines for PCT (WHO, 2009) as well as the National NTD protocols.

Phase 1 was used for planning for the scale up of the integrated MDA in Zamfara.

Phase 2: The objective for phase two of the programme was to pilot the integrated MDA at scale in Zamfara whilst continuing the existing NTD programmes in Kano, Katsina, Kaduna, and Niger States. The selection of Zamfara to pilot the integrated MDA was based on complete mapping of the diseases and the established CDT platform supported by Sightsavers since 1995. This allowed the UNITED programme to develop, test and implement the new systems and process required for expansion of MDA to the target diseases.

Although all drugs were successfully delivered to the targeted LGAs in the first round of MDA in Zamfara state, there were several external challenges (see below) that resulted in the target for the numbers of treatments not being achieved. A total number of 4,362,495 treatments for all diseases were administered, which was 83%

of the 2014 target (5,255,000¹¹). Apart from trachoma treatment, the programme did achieve its target for the number of LGAs to be treated.

External challenges:

- A cholera outbreak in some communities delaying the planned treatment.
- The impact of the Ebola outbreak (schools closed).
- Inaccessibility to some communities due to intercommunal violence in parts of the state resulted in some 200,000 people moving into Niger State.
- Delayed arrival of drugs corresponding with Ramadan and delayed treatment until fasting finished.
- Zithromax was only donated by Pfizer to three of the five endemic LGAs (due to a decision by Pfizer as a result of donated Zithromax being sold commercially).

Overall, in its first year, the UNITED programme implemented high quality integrated MDA with a higher than targeted therapeutic coverage apart from for schistosomiasis (see Appendix 1), (based on a post MDA coverage survey) despite the challenges that were out of the programme's control.

Phase 3: The third phase of the programme involved scaling up the integrated MDA to Kano and Katsina in September 2014, then to Niger and Kaduna in May 2015 and a second round of treatments in Zamfara. Although the four states of Kaduna, Kano, Niger and Zamfara have several years of experience with CDT, Katsina did not have any previous experience with CDT. The decision to implement MDA in all 30 LGAs at once proved too difficult and required support staff from Zamfara state being brought in to help with the roll out of the MDA.

As in the previous year, the programme was faced with several external challenges that impacted the MDA (detailed below) including no delivery of Zithromax and late delivery of Mectizan and Albendazole. This meant that no trachoma treatments were able to be administered during this phase, but despite this, the programme managed to reach 85% of the original target for 2015. Appendix 1, Figures 1-7 show the achievements by state against milestones by disease for 2015. It should be noted that for operational purposes, this achievement should be interpreted with some caution as there was inter-LGA variance in performance in some states with some LGAs achieving far below the targeted figure. Katsina performed the least well when achievement against milestone is considered (66% across all diseases and 75% for LF¹²). It is important to note that in Katsina, the MDA was carried out for the first time (in contrast with the other four states). Moreover, as the UNITED programme only recently started implementation in this state, the relations between the state and the UNITED programme implementing partner are still being developed. This may have contributed to the relatively low achievements seen in Katsina state. Conversely, Sightsavers has been operational for a long time in Kaduna and trachoma is not endemic, this potentially contributed to the state's high performance (95% across all diseases and 104% in LF), see Appendix 1, figure 6. In year two 2014-2015 some states achieved the recommended therapeutic coverage for some diseases e.g. Kaduna achieved the coverage for two of four diseases, Kano and

¹¹ Note this is based on the updated DFID logframe which has incorporated the so-called "stretch targets"

¹² LF figures is used in the programme as a proxy for numbers reached.

Niger achieved coverage for three of four diseases, Zamfara was border line for all two diseases treated and Katsina did not achieve any (Appendix 1, Figure 7).

The programme is using the LF coverage data as a proxy for the numbers of people reached in the MDAs as LF covers a larger population of the state so every other treatment is a subset of the population treated for LF. Thus the total number of people reached in 2015 was 22.3 million (21.3 million treated for LF and the rest for other interventions in areas where there is no LF).

Programme related challenges include death of a child purportedly due to treatment with praziquantel this was later found to be false, but had already had serious negative impact on the programme. There were side effects of praziquantel treatment that resulted in the need to change strategy to ensure children are provided with food on the treatment day. This has now been adapted throughout the Programme and in non-UNITED MDA programmes.

External challenges:

1. National elections in April 2015 led to suspension of field activities for six weeks, this particularly impacted the school-based STH programmes.
2. Late arrival of drugs, just before Ramadan so treatment was delayed until after the fasting period of one month ended.
3. The suspension of the duty and customs waiver for drugs by the Nigerian Government. This delayed the clearance of Zithromax (that left the warehouse in early November). At the time of writing, Crown Agents were still working to unblock this and hope it may be cleared by mid-January 2016. The change in Government and delay in appointing the Permanent Secretary of Health and lack of clarity around actual process involved, meant that little could be done by the Programme, Crown Agents or DFID to address the problem.

The importance of involving community and religious leaders from the outset was clearly seen from KIIs and community group discussions. Well informed and supportive community leaders can ensure participation and sustainability of the MDAs as well as acting as powerful advocates for state funding for the programme. Religious leaders can play a similar role, and are particularly important in urban areas where the MDA is more challenging e.g. in the case of LF and informing the communities about treatment for school aged children and reaching those not in school. In the three states visited by the reviewers, FLHWs, CDDs and school teachers interviewed confused transmission of the NTDs with e.g. malaria, guinea worm or had completely wrong ideas about disease transmission indicating the need for supervision of training.

Key informants also highlighted the need for extending the CDD training time, given the comprehensive data collection forms (especially in places where no previous CDT has taken place). The CDD work load and numbers of people they are expected to treat was also raised.

It appears that the programme sometimes fails to get full lists of schools, especially the private institutions and it is possible that children in such schools are often missed during MDAs. Effort has been made during programme implementation to reach all school aged children both enrolled and none enrolled. Not enrolled children

can also be invited by their enrolled siblings to receive their drugs in the nearest schools during the treatment days. During this consultancy the reviewers did not see evidence of this happening but anecdotally during the report discussion with Sightsavers examples that siblings were invited for treatment were mentioned in Kano and Zamfara

Logframe indicators for MDA from draft annual report to DFID 2015

Indicator(s)	Milestones		Progress	
	Date	Target	Date	Actual (% of target)
Number of treatments administered (by disease)	Sept 2015	LF: 23.759m Oncho: 6.467m Schisto: 3.176m Trachoma: 2.445m STH: 3.003m	Oct 2015	LF: 21,313m (94%) Oncho 6,195m (96%) Schisto: 2,847m (90%) Trachoma: 0 (0%) STH: 3,205 (107%)
Number of people reached annually with MDA	Sept 2015	23.759m	Oct 2015	22.3m (94%)
Therapeutic coverage (by disease)	Sept 2015	LF: 65% Oncho: 80% Schisto: 75 % Trachoma: 80% STH: 75%	Oct 2015	LF: 72% (109%) Oncho: 77% (95%) Schisto: 70% (87.5%) Trachoma: - (-) STH 95% (-)

Conclusions

The integrated MDA exercises in the five states are being successfully implemented, although the actual numbers of people treated in both 2014 and 2015 did not reach the targets due to the issue with drug delivery delays, which also resulted in somewhat lower therapeutic coverage.

Long-term success of the MDA will be dependent on sustained government funding at state level. As reported in section 3.2, although most state budgets do now have a budget line for NTDs, the concern raised at all levels is the difficulty in release of these funds, particularly when other health emergencies occur. Sustained impact will also depend on community-based approaches that emphasise health protection and promotion with planning and targets that are understood, supported and agreed upon by the entire community, including local authorities.

An ongoing issue for the NTD sector, MDA implementations is that of CDD incentives and this includes the UNITED programme, not only is there a concern due to other programmes that often use the same CDDs and pay them, but also that there are differences in how the UNITED consortium NGO partners provide incentives across the programme.

Recommendations

- Improved training, supervision and monitoring of the cascaded health education regarding basic epidemiology (transmission, vectors) of schistosomiasis and STH for FLHWs, CDDs and school teachers is needed. It was evident that the UNITED consortium is endeavouring to strengthen collaboration with other

community based-health programmes like immunisation, school feeding, polio immunisation, malaria and WASH to address this, however, more needs to be done in exploring and implementing collaboration with WASH (and other programmes) in supporting the NTD MDA, to improve the overall environment, particularly in urban areas (where rubbish, putrid waste water will maintain disease transmission).

- Although the programme is generally community driven with communities involved in planning, implementation and monitoring of the NTD programme, feedback to communities is still minimal and could be improved.
- Review of CDD training time given the comprehensive data collection forms and extra supervision during the MDA as well as attention to the CDD work load and numbers of people they are expected to treat
- Explore developing a minimum set of standard strategies for consortium partners when implementing MDAs (M&E, BCC, Logistics, CDD motivation) in line with national guidelines.

3.6 Governance and Coordination

The UNITED consortium is led by Sightsavers in partnership with a number of national and international organisations with expertise in HSS and financial accountability and logistics/ SCM; as well as academic institutions. Table 1 below outlines the partners, their roles and their geographic focus.

High level governance is provided by the UNITED governance team comprised of Sightsavers senior management staff in the UK; Sightsavers contract officer in Nigeria, and UK-based Crown Agents and HPI programme managers. This team provides oversight, technical assistance and donor relations.

Governance at country level is provided by the PMO, based in the Sightsavers Head Office in Kaduna. In addition to these governance structures, a Technical Advisory Group (TAG) was established in December 2015 to provide technical support and guidance for decision making. The TAG will act as a conduit for technical input and learning between UNITED and the national programme as well as at the international level.

Table 1 UNITED Consortium Partners roles

Consortium Partner	Role	Specific Focal State(s)
Sightsavers	<ul style="list-style-type: none"> - Manage the PMO - Manage the contract with DFID - Manage selected programme staff - Provide overall coordination of programme implementation - Complete any outstanding mapping - Implement MDA - Coordinate M&E by partners and the SMOHs - Introduce an electronic data management platform, using mobile technology. 	<p>All UNITED supported states for programme management and coordination, mapping (where relevant) and M&E</p> <p>MDA in Kaduna & Zamfara</p>
CBM	<ul style="list-style-type: none"> - Implement MDA - Manage selected programme staff 	Kano
MITOSATH	<ul style="list-style-type: none"> - Implement MDA - Manage selected programme staff 	Niger

	- Carry out Mapping	
HKI	- Implement MDA - Manage selected programme staff - Support BCC/IEC	Katsina + All UNITED supported states for BCC
HPI	- Technical assistance in HSS, - associated capacity building and linkages to other health sector programmes	All UNITED supported states
Crown Agents	- Organise drug supply logistics, build capacity in drug supply chain management.	All UNITED supported states
ADP	- Seconded programme management, finance and risk management staff to the PMO	All UNITED supported states

Findings, achievements and areas for strengthening

The clear roles and responsibilities between Sightsavers Head Office and the PMO office ensure an effective and efficient working relationship and the programme does benefit from support from the UNITED governance team.

All state and consortium partners interviewed highlighted that a key strength of UNITED lay in the consortium approach to implementation of the programme. At state level, stakeholders were positive about the fact that the programme provided access to support from a wide range of partners with specific technical expertise. As mentioned previously, support for HSS and SCM at the state level were cited as being particularly appreciated.

Consortium members all agreed that joint programme planning and harnessing the comparative strengths of each partner is a key strength of this model. This is achieved through an information sharing platform for consortium partners in the form of quarterly meetings, monthly reports and informal telephone conversations. As an example, Kano shared lessons learned from school-based MDAs with the programmes that had not started schistosomiasis MDA, prompting the implementing partners to coordinate with school-based feeding programmes to minimise the adverse effects of drugs being taken without food. It also influenced the Zamfara plan for their schistosomiasis treatments roll out.

While states are implementing NTD programmes in line with national and international guidelines, the consortium model allows partners to adapt implementation (without compromising technical quality) based on individual partners operating systems. There have been slight differences across different states for some aspects of MDA implementation. For example, in Katsina CDDs are not provided with visibility materials. These differences in implementation provide an opportunity for the consortium to capture and document lessons around the MDA implementation, linked to results achieved and contribute to the national discourse on NTD MDA implementation best practices. This opportunity for learning could be enhanced through a more formal documentation and communication plan.

The added value of the UNITED consortium is also being transferred to non-UNITED supported states. The consortium partners interviewed highlighted that they had implemented lessons (e.g. logistics management, project reporting, improved financial accountability) from the UNITED programme in states they support outside of the UNITED programme.

The role of the PMO was viewed positively by all interviewees as they are seen to provide a strong coordination function within the programme. At times though, overlapping activities (e.g. partners arriving in state to train people who had been called away by other members within of the consortium for a different activity) occurred and both consortium partners and the SMOH advised that coordination in responsiveness to changes/delays to plans needed strengthening.

A number of initiatives have been introduced as part of programme management to foster efficiency and coordination, these include:

- Communications and reporting: monthly reports from the partners which is followed by telephone conversations between the reporting partner, the PMO and Sightsavers UK to highlight any bottlenecks and agree on required actions. This reporting process is viewed by partners as a valuable resource that improves efficiency and open communication in all areas including financial management
- All consortium partners meet on a quarterly basis to report on achievements, challenges and share lessons to the wider consortium.

Value for Money: In terms of VFM, the following initiative is in the process of being implemented.

- A VFM Dashboard has been developed by ADP. At the time of this midterm review the VFM dashboard had not been operationalised yet but its purpose is to capture key cost drivers of elements of the programme. It will make it possible to compare costs across programme elements (e.g. MDA costs across states) thereby adding valuable analytical features by making it possible to compare costs across initiatives, identify outliers and initiate cost saving initiatives across states.
- A member of Sightsavers UK attended VFM training (BOND) and is part of the VFM working group within Sightsavers as well as the VFM working group between DFID and other NTD NGOs. Participation in these groups provides opportunity to share wider learning on VFM with the UNITED programme and learning from UNITED to other DFID Programmes being implemented by Sightsavers.

A number of software systems are being used by the programme to streamline work and free up time for “value adding” activities. These software systems including *CLAIMS*, *Proactis* and *Standard Lists* all contribute to streamlining the accounting, financial management, procurement processes within the programme. These financial management and procurement systems also contribute to controlling costs and ensuring quality and transparency in the procurement process. Furthermore, the contractual nature of the programme (i.e. partners being reimbursed upon achieving set targets) fosters efficiency, accountability and added incentives for achieving programme targets.

In terms of internal control, financial management is based on UNITED financial management policies as well as other Sightsavers frameworks and policies. Standardised processes and templates for (re-)budgeting exist using agreed baseline figures and actuals. The *CLAIMS* and *Proactis* software’s are used to track spending and to provide financial reports including narrative questions and supporting documents for clear and permanent audit trail. A clear chain of checks

and balances exists stemming from the PMO office through to the Sightsavers UK Finance Team and the Sightsavers programme director.

In country, the finance officer in the PMO carries out regular partner audits and provides training and capacity building to partners as needed.

A potential area for inefficiencies lies in over budgeting by partners. It appears that partners may do this to account for unforeseen circumstances but it has the potential to make the forecasting less accurate and front load resources. The Sightsavers UK team are aware of this and are working with partners to improve the process based on actual costs and treatments costs to date as a point of reference.

Conclusions

It is clear that there is a strong coordination structure in place that is positively viewed by both consortium and government partners. The consortium model is viewed as a key strength of the programme and the cross learning is being disseminated by partners to their non-UNITED programme states.

There is a strong framework for programme, financial management which is fostering an efficient and target oriented programme approach. The use of programme and financial management software such as CLAIMS, Proactis and Standard lists as well as the close working relationship between Sightsavers UK Finance and the PMO appears to contribute to achieving VFM within the project.

The operationalisation of the VFM dashboard will constitute a tool that can be used to report cost analysis and to look at aspects of VFM, when completed and adopted. It will provide an opportunity for learning across states and identify any potential areas for improvement.






Recommendations




- Improve the responsiveness of programme plans to changes/delays in activities in order to reduce overlapping of activities.
- Capture lessons around the different modes of implementing MDAs and use this to contribute to a national platform on best practices for MDA implementation.
- Operationalise the VFM dashboard as a matter of urgency in order to utilise its features in informing programme implementation in the remaining years of the programme.
- As the reviewers had difficulty in analysing quantitative data from the programme because information is contained in multiple spreadsheets (milestone tracker, stretch and non-stretch targets, treatment database, different versions of the logframe and different indicators in the annual report) it is recommended that there should be a coherent M&E system that is aligned with the UNITED DFID logframe with quality assurance of M&E at the PMO office ensuring documents are dated with latest version of document clearly identifiable, numerators and denominators are clearly defined within the document and assumptions are outlined.





3.7 Key evaluation questions/criteria and ratings








In order to be able to give an overall rating for the seven evaluation criteria (as in the executive summary), the consultants rated each of the key evaluation questions using evidence from available documentation and KIIs. Information from KIIs was only used if it could be verified from at least two other sources.







The decision on the rating was based on the Sightsavers evaluation criteria ratings (Appendix 6) as follows: excellent = strong evidence that the project fully met or almost met all aspect of the question; Satisfactory = strong evidence that the project mostly met the aspects of the question – but room for some improvement; Attention = evidence that the project only partially met the aspects of the question. The process by which the three consultants came to the rating is given in the methodology Section 2.





	Key Evaluation question to be addressed	Rating	Comments
	<i>Relevance</i>		The UNITED programme addresses the control of PCT diseases and is consistent with Nigeria's Master Plan for Neglected Tropical Diseases and State National NTD Plans
1	How is the programme addressing the National NTD priorities?		UNITED programme addresses control of PCT diseases and is consistent with the Nigeria Master Plan for Neglected Tropical Diseases and State National NTD Plan. The five states were chosen due to the high burden of NTDs.
2	How relevant is the programme to the health needs of the target beneficiaries?		Most target beneficiaries do not see NTDs as major health issue. KII with SMOH, LGA and community level reported Malaria as the highest priority (underscores the fact that the NTDs are still neglected). They were pleased with the drug administration for NTDs and ancillary benefits
	<i>Effectiveness</i>		There is clear value in the consortium model – particularly through the skills of the core partners. The rating is brought down by the BCC component which needs strengthening at all levels from national to community and the M&E component needs to be reviewed and implemented in line with the BCC strategy. Integration of MDA activities is evident at all levels and cost effectiveness through time saved through the joint planning and training activities. Likewise the new management processes are promoting efficiency but the weakest area remains the BCC strategy that needs to be strengthened with a clear action plan for advocacy, communication and better utilisation of the influence of traditional leaders in the community.
3	What is the value added in terms of using the Consortium model as opposed to parallel donor - NGDO funding streams for the different states?		There is value-added in terms of the consortium model in terms of joint working/planning, information sharing and access to a wider range of expertise and skills. From the State MOH perspective the added value was in the skills provided by the core partners. Need were identified for continued improvement of the model through: <ul style="list-style-type: none"> • Harmonising the ways of working despite

	Key Evaluation question to be addressed	Rating	Comments
			<p>individual institutional practices;</p> <ul style="list-style-type: none"> • A lack of strong UNITED brand: individual partners in each state were recognised but the UNITED consortium was not well recognised at state level. • An action plan should be formulated to address issues but evaluation findings are potentially a reference for good practice.
4	What are the key determinants for the achievement of outputs and outcomes?		All MDA activities were integrated effectively at State and LGA level. Cost effectiveness was seen in terms of time saved through the joint planning & training activities and the drug supply chain strengthening (including delivery of drugs to the LGAs)
5	<p>What are the key determinants for the achievement of outputs and outcomes?</p> <p>If the outputs/outcomes are not achieved, what are the reasons?</p>	N/A	<p>Achievement of outputs and outcomes</p> <ul style="list-style-type: none"> • Harnessing of the complementary skills of the consortium partners and strong PMO coordination • The contribution of ADP and UNITED UK to programme & financial management • Sustained MDA levels & using results of M&E for changes in strategy <p>Non achievement of outputs/outcomes</p> <ul style="list-style-type: none"> • Potential risks not mitigated in a timely fashion
6	Have the management processes and systems developed ensured the effectiveness of the programme and if so, how?		<p>Management processes have been developed that promote the effectiveness of the programme.</p> <ul style="list-style-type: none"> • Joint planning at quarterly meetings • The monthly reporting system that has been developed. Reports are validated by a skype call to discuss the monthly report providing an opportunity to discuss issues, challenges and solutions • Partners are paid based on targets achieved.
7	Is evidence from research and M&E activities being used to review programme performance or direction?		<p>There is evidence that results of research and M&E activities are being used to inform programme activities. E.g.:</p> <ul style="list-style-type: none"> • Results of Loa surveys to determine MDA strategy in Katsina, Kaduna and Kano; • The KAP survey was used to develop the BCC strategy for the programme; • Results from the therapeutic coverage validation used to learn lessons about MDA implementation challenges. <p>There is room for improvement e.g. strengthen operational research to inform wider national NTD programmes. There is evidence of research discussions and planning in the national NTD Steering Committee, but less evidence of how it is being used. As reported elsewhere, there is a need to strengthen the BCC M&E in order to understand better the effect of the programme efforts in the area.</p> <p>UNITED needs to improve its external communication. Internal communications are good, but the UNITED newsletter circulation seems limited to direct stakeholders and adding other stakeholders</p>

	Key Evaluation question to be addressed	Rating	Comments
			<p>like MDP, pharmaceutical donors (and associations) APPG etc. would be constructive.</p> <p>The COUNTDOWN initiative will be relevant but may still be at inception stage at the end of the UNITED Programme.</p>
8	To what extent has the Behaviour Change Communication strategy been successfully implemented?		<p>The BCC strategy is heavily dependent on radio jingles and community sensitisation appeared to be weak.</p> <ul style="list-style-type: none"> The M&E plan articulated in the BCC strategy is not currently being implemented. The current monitoring strategy based on using a single consultant for all states and at all implementation levels is insufficient. Some front line health workers, CDDs and communities visited displayed limited knowledge of the transmission and prevention of NTDs. Responses were often related to the prevention of malaria and guinea worm. <p>There needs to be a clear action plan for advocacy, communication and better utilisation of the influence of traditional leaders in the community.</p>
	<i>Efficiency</i>		Overall, the UNITED programme has put in processes that ensure maximum efficiency
9	Is there evidence of inefficiencies in the way the programme is being implemented, particularly the allocation of resources (human, material and financial)? If so, how might these be improved?		<ul style="list-style-type: none"> Some evidence of inefficiencies in M&E reporting (e.g. multiple different documents using different formats), overlapping activities planned by consortium partners, documenting of outcomes and implementation of research. For the national NGOs, the fact that the UNITED programme is a contract and not a grant, meant that they did need an advance to cover costs and there is considerable risk to the consortium if partner budgets are set too low in any given year.
10	What mechanisms are in place to ensure value for money?		<ul style="list-style-type: none"> The outcome indicator on the logframe is “Number of states with financial cost per person treated determined and unit cost \leq 0.25 USD / treatment” but no milestones for 2014 or 2015 have been determined. A methodology to calculate this is cost is in development for this analysis Systems are in development but the planned VFM dashboard was not ready at the time of the review so not possible to rate something that has not been operationalised yet. As this is year three of the programme, accelerating and operationalising the dashboard to be able to capture the costs is important

	Key Evaluation question to be addressed	Rating	Comments
11	What internal control mechanisms does the consortium have in place to ensure funds received are well managed?		<ul style="list-style-type: none"> • Good software, good training and relationship between UK, PMO office • Regular audits
12	What measures are in place to improve partners' skills in programme and finance management?		<ul style="list-style-type: none"> • The UNITED Finance Officer carries out regular partner visits to assess skills • CLAIMS training and feedback survey Audits provide recommendations where possible • ADP's work on programme management and development of the tools
	<i>Impact</i>		There is clear evidence of the success of the of HSS and strengthening the drug SCM - however the <i>impact</i> of these cannot be seen at this point in the programme
13	What processes are in place to ensure long term changes in terms of strengthening health systems and improving access to health care services?		<p>Clear evidence that HSS processes have taken place and are ongoing.</p> <ul style="list-style-type: none"> • HPI have supported a series of training programmes including leadership, computer training. They have also improved management systems by supporting the introduction of job descriptions (the introduction of NTD cadres at various levels e.g. State/LGA NTD coordinators)
14	Are there any unintended positive or negative effects of the programme?		<p>Only positive effects were reported</p> <ul style="list-style-type: none"> • Institutional learning/experience used in other (non-UNITED Supported) State NTD programmes. • FMOH interested in applying some of the systems established by UNITED elsewhere in the country
	Sustainability		There is a clear commitment to an exit strategy and a robust approach being developed to a transition plan that is looking realistically at what can be assumed by the government and where the gaps are, with planning for finding ways of addressing funding and implementation gaps
15	To what extent, has the NTDs programme developed strategies for programmatic sustainability? E.g. to what extent has the capacity of the FMOH been built in the areas of drug supply chain management?		<ul style="list-style-type: none"> • An exit strategy, a consolidated transition plan as well as state specific transition plans are at various levels of development. • In drug SCM, the new LMIS that has been introduced is leading to increased accountability for drugs at all levels. • State store officers have been trained. However, the transportation of the drugs from the central medical stores to the LGA level is heavily dependent on Crown Agents and raises questions about the sustainability of this component of the programme. • Responsibility for drug quantification and the capacity to carry it out at State Ministry of Health level is still questionable as KILs in Katsina and Zamfara were not clear as to how drug quantification is carried out and by whom – also apparent from KIL with Crown Agents (see Section 3.4).

	Key Evaluation question to be addressed	Rating	Comments
16	What are the major factors at the Local, State and National Government system level which influence, or may influence, the financial and programmatic sustainability of the programme?	N/A	<ul style="list-style-type: none"> Buy-in and commitment at the highest level of government which is translated into the inclusion of NTDs in the state budget and timely release of funds. Urgent development and implementation of an action plan for high level advocacy.
17	How robust is the approach being used to develop the exit strategy?		<ul style="list-style-type: none"> The high level transition plan reviewed by the consultants indicates a robust approach to the exit strategy although the consultants did not see the exit strategy or the state transition plans. However, there is a high level of awareness at all levels of the importance of a robust exit strategy. HPI is working with states to develop transition plans and States are aware of the need to advocate for the inclusion of NTD in the state health budget that need to be in place by 2016. The development and the implementation of the high level advocacy action plan will improve the robustness of the exit strategy.
18	To what extent are community members or their representatives involved in programme planning, implementation and monitoring?		District leaders, village councils (headed by the village head) and traditional religious leaders all reported being involved in the planning and implementation of MDAs through a meeting called at each LGA level.
	<i>Scalability / replication</i>		There is evidence that process and strategies are in place to replicate and scale up programmes, but there is room for improvement e.g. a formal process for capturing evidence base for scalability for dissemination to stakeholders outside the UNITED consortium, e.g. an annual lessons learned review
19	What processes or initiatives are there in place to generate the evidence base for scalability/replicability?		Processes exist for capturing best practice through the monthly and quarterly reports/ meetings. However, there is no formal process for capturing evidence base for scalability for dissemination to stakeholders outside the UNITED consortium, e.g. an annual lessons learned review.
20	What are the strategies implemented to document, communicate and disseminate information about the project to broader stakeholders?		A newsletter that is disseminated to stakeholders seems to be the main mechanism as the consultants have not seen a communications strategy. The newsletter could be sent to a wider group of stakeholder's e.g. WHO, BMGF, the various organisations that formed round UNITED to combat NTDS, APPGNTDs etc. An effective communications strategy/plan needs to be developed and implemented.
21	How have the lessons from the pilot phase been used in scaling up activities in the additional states?		This question is specific to the pilot phase, hence the rating. Evidence of lessons learned from the inception phase in Zamfara being utilised to scale up activities in additional states was not clearly presented (or obvious) to the reviewers, although It

	Key Evaluation question to be addressed	Rating	Comments
			<p>was clear that the results of the KAP survey influenced the development of the BCC strategy¹³. There was anecdotal evidence of cross learning across states for MDA implementation. For example</p> <ul style="list-style-type: none"> • Inclusion of feeding requirement before administration of PQZ adopted in Katsina after the experience in Kano • Zamfara was able to benefit from lessons regarding schistosomiasis treatment from other States (it had not started treatment yet) • Refinement of community engagement to place emphasis on the use of traditional leaders to promote uptake.
	Coherence/coordination		Overall, there is good coherence of the programme with the national and global context. Coordination between consortium partners and State and Federal MOH is good. Coordination/collaboration with other stakeholders health programmes and could be improved
22	Is the design/approach of the intervention appropriate considering both programme objectives and the context in which the programme is implemented?		The design and approach are appropriate for the programmes objectives (as articulated in the introduction) and in the broader context of integrated NTD control and elimination programme goals of WHO, and towards achieving the London Declaration Goals for 2020
23	What coordination mechanisms are in place and how well are they functioning?		The PMO office is providing strong programme coordination and an information sharing platform for consortium members. The integrated planning and training activities also allow good coordination (although there is room for improvement in some cases where partner training activities overlap). Coordination with the national NTD steering committee and NGDO coalition group is evident through meetings minutes shared through the various NTD committees and consortium
24	How well integrated is the programme into other health and education programmes in the States, particularly those which are DFID and USAID funded?		The consultants were not able to meet with other relevant programmes so have only document review and anecdotal reports as evidence of some areas of collaboration and integration e.g. mapping and training with the RTI- ENVISION programme. Opportunities exist to link up or strengthen ties with e.g. WASH, MNCH, Malaria, Polio programmes in several areas including discussion regarding CDD incentives, drug delivery, trainings and community-based approaches that emphasize health protection and promotion. There would seem to be more opportunities for bringing the Nigerian DFID funded programmes overseen by both the Nigerian and UK DFID focal persons together that are not being capitalised

¹³ Note that learnings from Zamfara were discussed and disseminated at a meeting after the pilot phase – but the reviewers were not informed of this by KIIs.

3.8 Summary SWOT analysis in table format based on observations and analysis

The strengths, weaknesses, opportunities and threats (SWOT) analysis of the programme and partnership was developed based on responses from the KIIs and FGDs, supported by triangulation of information obtained and document review by the consultants.

Overall, the strengths of the UNITED programme are reflected from using the consortium model that brings skills from different partners and allows them to focus on what they do best overseen by an effective project management office and this results in efficient management and through minimising transaction costs using joint planning, monitoring and accounting. The weaknesses reported are mostly due to experiences coming from implementation. The opportunities identified are for expanded/ improved collaboration at different levels and the threats identified can be mitigated for before the end of the UNITED programme to some extent.

	BCC	HSS	Cap building for SCM	MDA	Governance/Coordination
Strengths	<ul style="list-style-type: none"> - Development of the radio jingles is an added value to the overall national NTD IEC campaigns as well as for the UNITED consortium programme 	<ul style="list-style-type: none"> - Capacity building including creation of NTD cadres at various levels in State, LGA, including job descriptions giving people clear understanding of their roles and expectations of them– leading to feeling valued and empowered - Creation of NTD task force in all five States - Inclusion of NTD indicators in the ISS - Integrated planning and training activities at state level. - National and state co-ordination in place 	<ul style="list-style-type: none"> - Effective /efficient process in place for UNITED and national NTD programmes - Built required skills for supply chain management that is extending beyond UNITED NTD programme - Integration of stores, reporting and personnel 	<ul style="list-style-type: none"> - Implementation of the Integrated MDA strategy - System for MDA at LGA and community is strong in States where a CDTI platform existed prior to the programme commencement - Beneficiaries happy with the drugs and aware of benefits - Availability of clear strategies, protocols & guidelines for MDA delivery 	<ul style="list-style-type: none"> - New management process e.g. reporting, communications. - Integrated planning and training activities - Role of the PMO office - Information sharing platform for consortium stakeholders - Institutional learning/experience used in other (non-UNITED Supported) State NTD programs
Weaknesses	<ul style="list-style-type: none"> - Monitoring of the implementation of the BCC strategy during the MDA. 	<ul style="list-style-type: none"> - Lack of strategy/plan for high level advocacy 	<ul style="list-style-type: none"> - Reverse logistics was not in Crown Agents ToRs and is consequently weak 	<ul style="list-style-type: none"> - Training period of CDDs too short (new data collection forms complicated) 	<ul style="list-style-type: none"> - Overlapping activities - Perceived lack of responsiveness was raised by 3 of the KIIs

	BCC	HSS	Cap building for SCM	MDA	Governance/Coordination
	<ul style="list-style-type: none"> - No evidence of BCC monitoring and evaluation protocol. - Clarity on the relationship between the BCC strategy and its implementation. - No evidence of establishment of BCC committee at state level. - No evidence of BCC implementation reports. - No evidence of advocacy teams. 		<ul style="list-style-type: none"> - Crown Agents have not actively looked for ways to deliver services through existing systems that would promote sustainability - Sustainability of transport of NTD drugs post UNITED/ DFID funding - Capacity for NTD drug quantification at state and federal level not demonstrated - Clarity on drug quantification process 		interviewed.
Opportunities	<ul style="list-style-type: none"> - Use of strong influence of traditional rulers in promoting uptake in implementation states. 	<ul style="list-style-type: none"> - Collaborating in an effective way with WASH, MNCH, Malaria and other Ministries e.g. Education. 	<ul style="list-style-type: none"> - Receptiveness of the FMOH to roll out Crown Agent Supply Chain Management process to non-UNITED supported states - Availability of skilled logistics staff up to LGA level to promote sustainability. - Exploring where NTD drug delivery can be integrated within existing supply chains. 	<ul style="list-style-type: none"> - Use the MDA advocacy, sensitisation and mobilisation to educate and motivate community and political leaders for both MDA activities and health environment issues - Explore ways to increase and improve engagement with partners that work on morbidity control for LF and Trachoma. (TB/Leprosy) and Leprosy mission. 	
Threats	<ul style="list-style-type: none"> - Lack of continued funds for the IEC campaign (radio stations etc.) post DFID funding 	<ul style="list-style-type: none"> - Attrition of staff - As with many programmes, success is dependent on individuals and change in staff can 	<ul style="list-style-type: none"> - Multiple vertical supply chains. - Drug supply not coordinated with MDA 	<ul style="list-style-type: none"> - Side effects of praziquantal - Drug supply delays - Low therapeutic coverage 	<ul style="list-style-type: none"> - Wind up of the PMO office at the end of DFID funding support and resulting loss of strong coordination

	BCC	HSS	Cap building for SCM	MDA	Governance/Coordination
		impact the project		<ul style="list-style-type: none"> - Elimination goal not achievable if adults and children in high risk communities are not treated for schistosomiasis - Constant issue of incentives for CDDs - Drug supply not coordinated with MDA 	

4. Summary/Conclusion

In summary, overall, the UNITED programme has made impressive progress towards its stated objectives and milestones, despite several external challenges that prevented some milestones being reached. The consortium model has demonstrated added value in harnessing the complementary skills of different partners – particularly the inclusion of those involved in health system and supply chain strengthening - and the joint planning and training. The PMO office is providing valuable coordination and governance for the consortium partners as well as an information-sharing platform. There are some areas that could be strengthened as highlighted in the recommendations.

As the programme enters its third year, the work on the transition plan should be accelerated in order to be able to define clear roles and responsibilities for the FMOH, SMOH, Sightsavers and the other NGDO partners. It is clear that the NGDOs will continue to be involved in the integrated NTD programmes – particularly due to some of the pharmaceutical companies requirements for donation of drugs - but the Nigerian Government needs to own and be responsible for this programme.

In this mid-term review it is not possible to report on the sustainability or impact of the health system strengthening, capacity building for drug supply chain management or the BCC strategy, this is something to flag for the final evaluation.

Key Recommendations that emerged from the review

For the UNITED programme including the FMOH

1. Development and implementation of an advocacy and communication plan as a programme activity: high level advocacy is urgently needed for buy-in and commitment to the NTD programme at all levels of National and State MOH as well as with traditional and religious leaders.
2. Implement a continuous process of BCC over the course of the year, not just at MDA time
3. HKI (with input from other consortium members if needed) should support its staff in Katsina to build a stronger relationship with the SMOH.
4. Federal and State level should be encouraged to develop plans for advocacy and resource mobilisation for when UNITED funding ends (including from private sector).

For UNITED, FMOH and DFID

5. Plan for how the surveillance will be carried out for diseases where the threshold for treatment has been reached - operational and funding
6. Utilise opportunities to improve collaboration with other DFID funded health and development programmes in Nigeria (e.g. annual workshops involving all programmes).

Supply chain (UNITED, FMOH)

7. Ensure there are mechanisms to sustain the integrated drug storage system and integration into the national supply chain of the tools and process introduced by Crown Agents for the UNITED programme

8. Further Improve implementation of reverse logistics by identifying funding options and clarifying roles and responsibilities

Coordination/collaboration (UNITED, FMOH, SMOH)

9. Find ways to improve collaboration with other NGOs and organisations involved in school feeding for the schistosomiasis programmes, stronger collaboration with SUBEB and advocate that government strengthens these links
10. Adults as well as children in high risk communities will need to be included in annual MDA's as stipulated in WHO guidelines - all areas where baseline prevalence of infection is 50% and above, in order to reach the programme milestone for schistosomiasis (caveat is that Praziquantal is donated only for school-aged children).
11. School-based activities are the responsibility of the Ministry of Education and the involvement of health workers in the planning and implementation of school based MDAs needs to be strengthened, particularly in the management of adverse events.

MDA (UNITED, FMOH, SMOH, DFID)

12. When potential or actual drug supply problems occur, act quickly and consider using high-level global stakeholders to help unblock the problem
13. Attention needs to be paid to CDD work load and actual numbers of people they are treating

BCC (UNITED)

14. The BCC/IEC component of the UNITED programme needs to be strengthened at all levels from the national to community level.
15. The M&E component of the BCC strategy needs to be reviewed and implemented in line with the BCC strategy in order to reach the project targets

Other Recommendations for UNITED to consider

UNITED programme, including the FMOH

1. Explore developing a minimum set of standard strategies for consortium partners for implementing MDAs (BCC, Logistics, CDD incentives, M&E)

Coordination/ collaboration (UNITED, FMOH, SMOH)

2. Explore how to work with organisations working on palliative/morbidity care for LF e.g. with the tuberculosis/leprosy programme, Leprosy Mission, handicap international etc.

MDA (UNITED, FMOH, SMOH)

3. As community and religious leaders will be critical in sustaining the MDAs, consider a specific, annual IEC programme for them.

M&E (UNITED, DFID)

4. Ensure a coherent M&E system that is aligned with the UNITED DFID logframe with quality assurance of M&E at PMO office e.g. ensure documents are dated,

numerators and denominators are clearly defined within the document, and assumptions are clearly outlined.

5. Recommend a due diligence process to identify where consortium members are using different templates with a view to implementing standardised templates for the UNITED programme across the five States and implementing partners.

BCC

1. BCC monitoring should be built on existing routine monitoring systems.

5. References

Hotez P.J., Ottesen E., Fenwick A., Molyneux D. (2006). The neglected tropical diseases: the ancient afflictions of stigma and poverty and the prospects for their control and elimination. *Adv Exp Med Biol.* 582:23-33

Hotez P.J., Fenwick A., Savioli L., Molyneux D. (2009). Rescuing the bottom billion through control of neglected tropical diseases. *Lancet.* 373:9674 1570-1575

Women and Trachoma (2009). The Carter Centre and Kilimanjaro Centre for Community Ophthalmology. Report on Achieving Gender Equity in the Implementation of SAFE. Downloaded from http://www.cartercenter.org/resources/pdfs/health/trachoma/women_trachoma.pdf on 1st December 2015.

Washplus Project (2013). Integrating WASH into NTD Programs: A Desk Review downloaded from http://www.washplus.org/sites/default/files/wash_ntds2013.pdf on 1st December 2015.

WHO - Asaolu S.O., Caines K., Crompton D.W.T., Diallo A.S., Ndiaye J.M., Njie A.B.H. (2008). Methodology for evaluation of neglected tropical disease control programmes at country level. Downloaded from http://www.who.int/neglected_diseases/Methodology_ntd.pdf on 1st December 2015

WHO (2006). Preventive chemotherapy in human helminthiasis, coordinated use of anthelmintic drugs in control interventions: a manual for health professionals and programme managers. October 29, 2009. Downloaded from http://www.who.int/neglected_diseases/preventive_chemotherapy/pct_manual/en/index.html. On 1st December 2015.

Appendix 1: Achievements against therapeutic coverage milestones

Figure 1: Kaduna 2015 achievements against milestones by disease

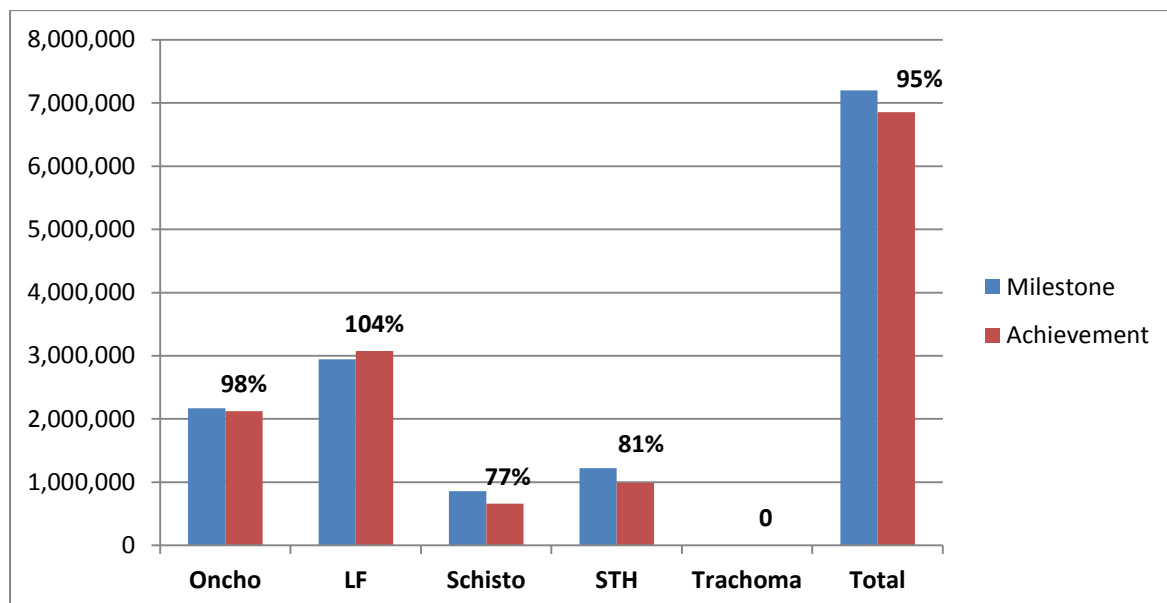


Figure 2: Kano 2015 achievements against milestones by disease

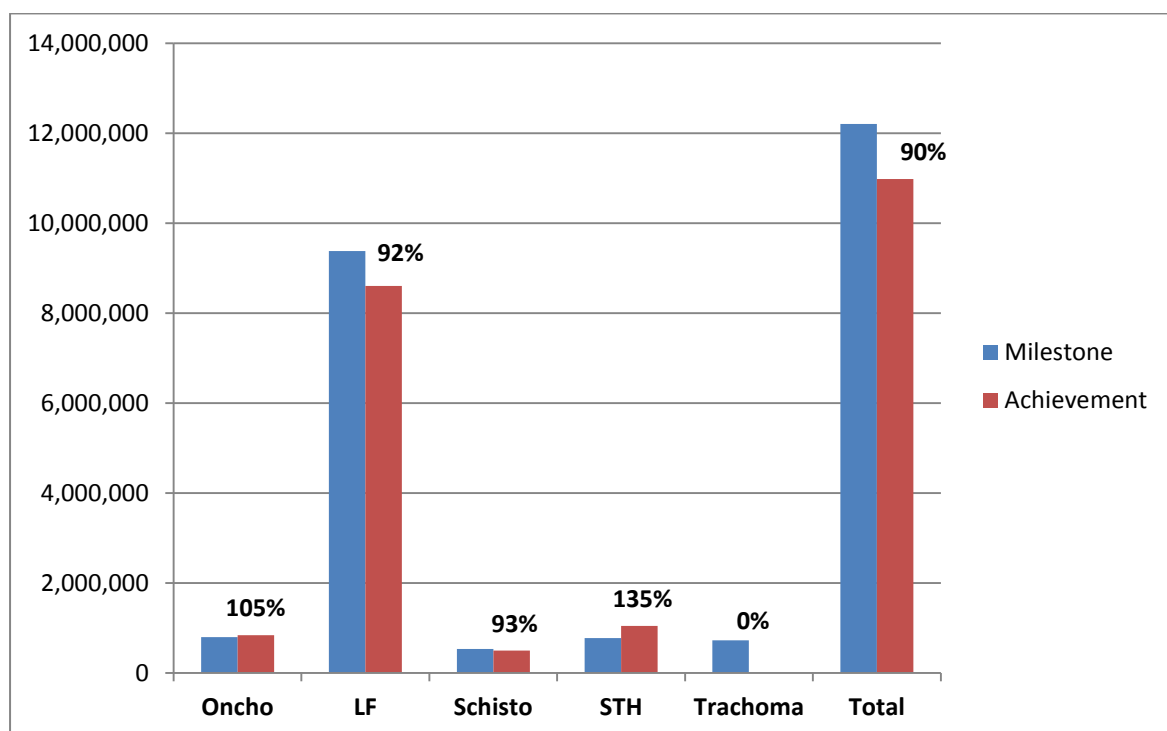


Figure 3: Katsina 2015 achievements against milestones by disease

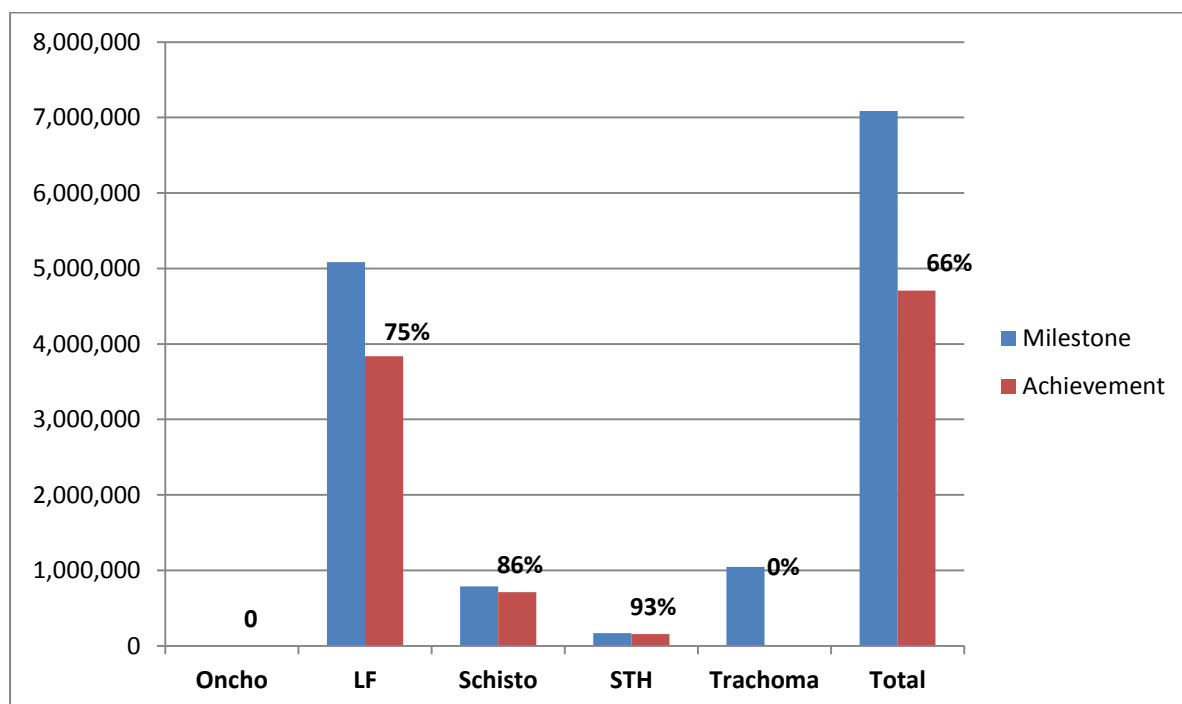


Figure 4: Niger 2015 achievements against milestones by disease

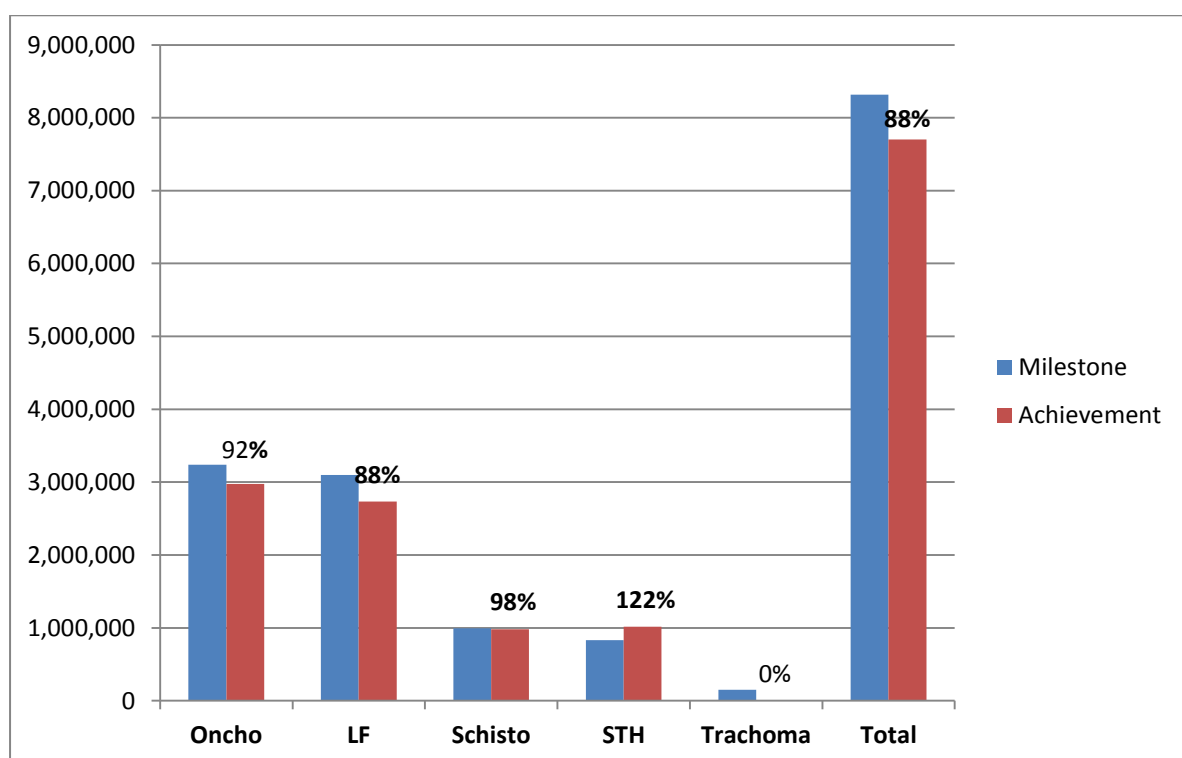
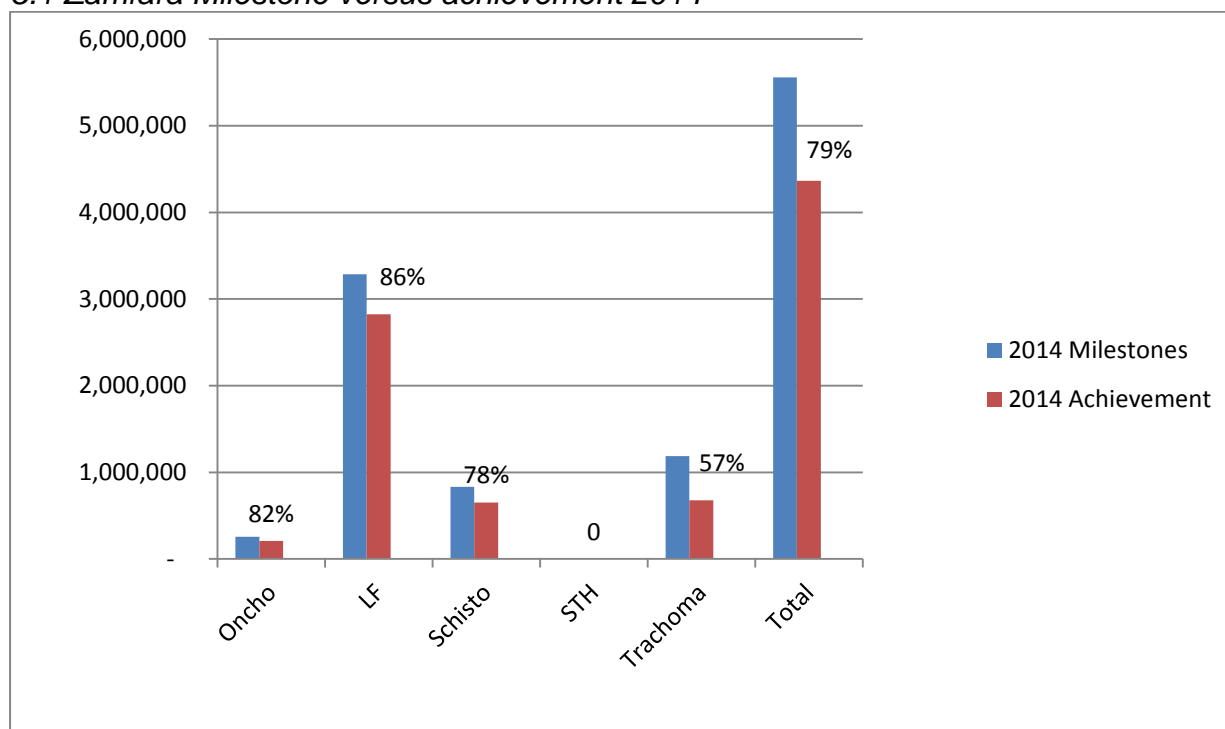
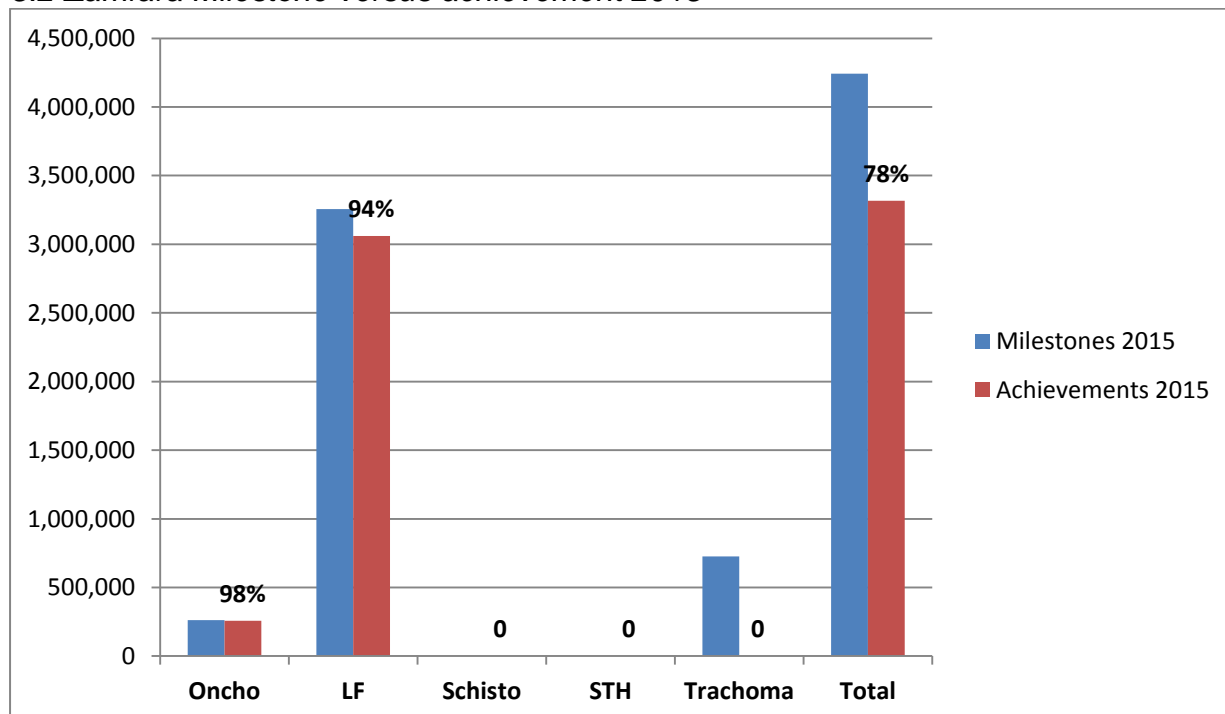


Figure 5: Zamfara achievements against milestones by disease

5.1 Zamfara Milestone versus achievement 2014



5.2 Zamfara Milestone versus achievement 2015



5.3 Zamfara Milestone versus achievement 2014 versus 2015

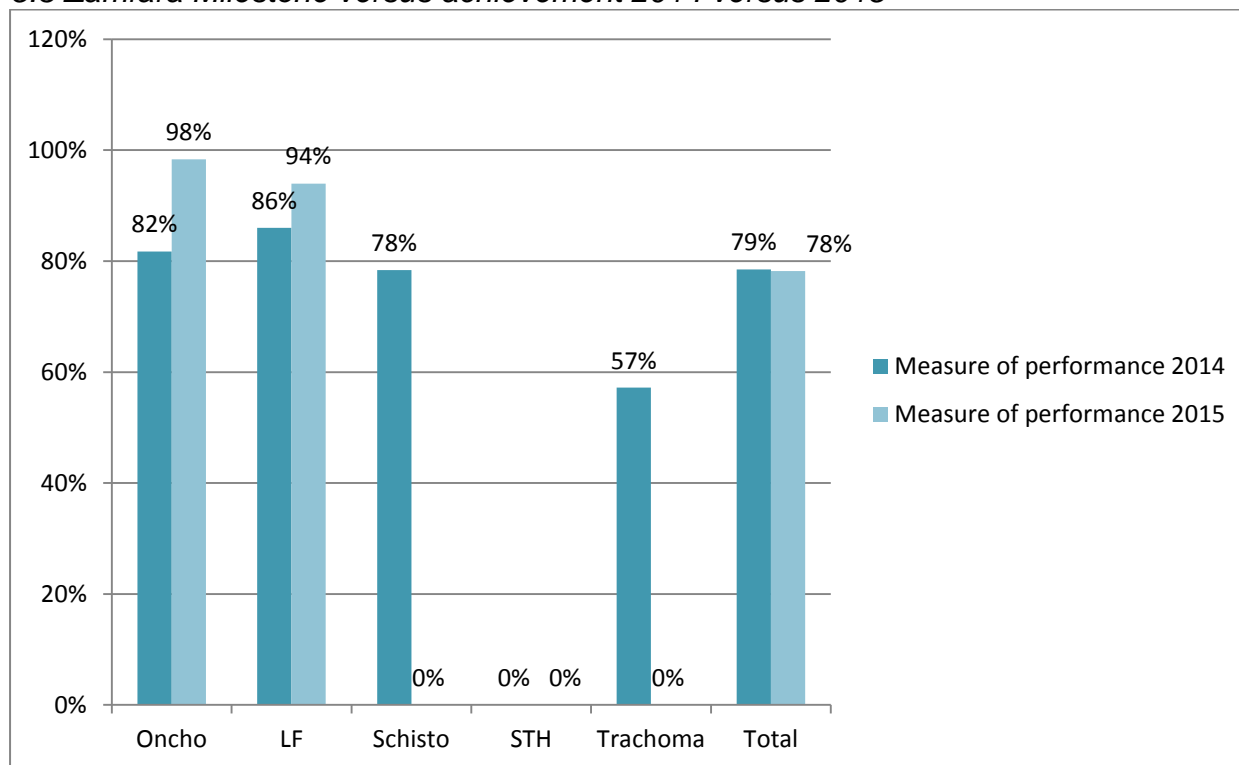


Figure 6: Overall measure of performance all diseases versus LF only

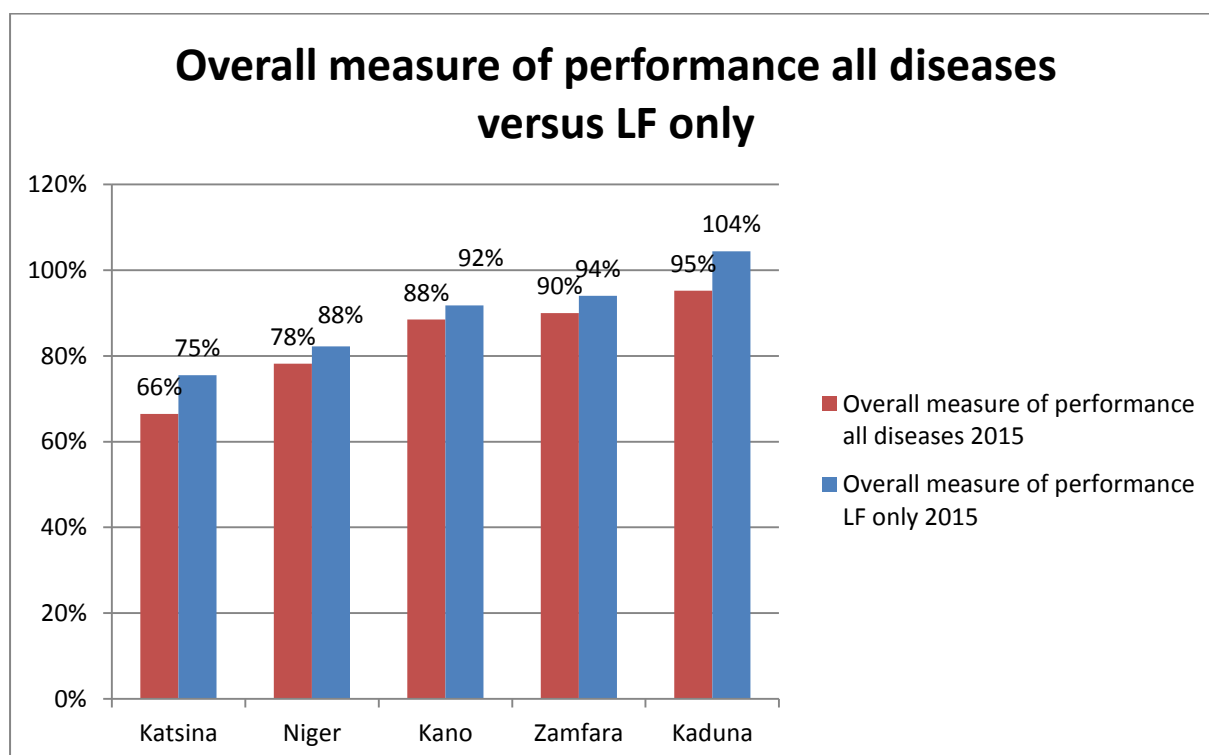
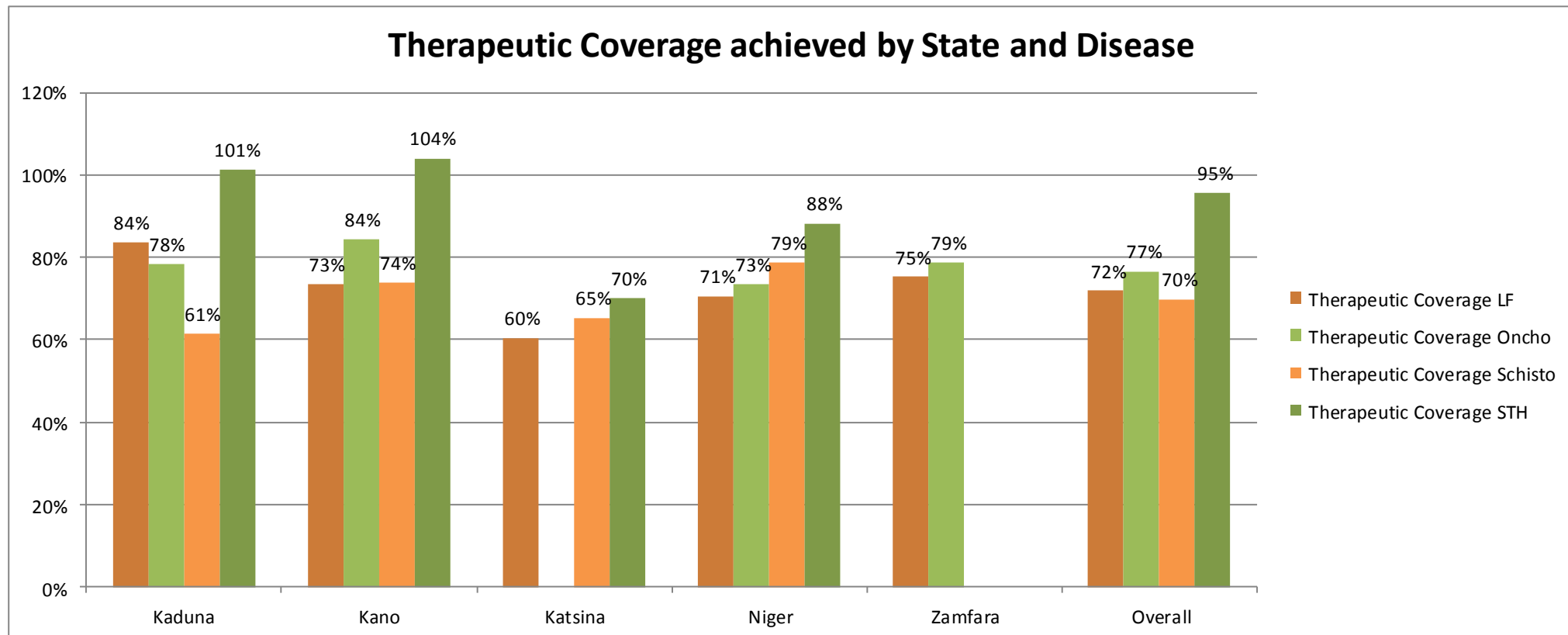


Figure 7: 2015 Therapeutic Coverage Oncho, LF, Schisto and STH



Appendix 2: List of main documents reviewed

	Documents Reviewed
	Global Policies, strategies and plans
1	1st WHO report on NTDs
2	2nd WHO report on NTDs
3	3rd Reporting uniting to combat NTDs
4	3rd WHO report on NTDs
5	Disability Framework 2014
6	Global NTD Plan 08 - 15
7	NTD Roadmap
8	SG Synthesis Report - Road to Dignity by 2030
9	World Health Assembly Prevention, Control and Eradication of NTDs 2013
10	Uniting to Combat NTDs
11	London Declaration on NTDS
	National Policies, strategies and plans
12	Nigeria NTD Control Masterplan 2013
13	NTD Policy for Nigeria, final draft 2014
14	NSHDP
15	National NTD Steering Committee documents (meeting summaries, members list etc.)
	Project Documents
16	UNITED ways of working
17	MOU with FMoH
18	SOW with FMoH
19	Project terms of reference
20	Technical Proposal
21	Commercial tender
22	Organogram
23	Sub-Contractor services agreements HPI, Accenture, Christian Blind Mission, MITOSATH, Crown Agents, Helen Keller International
24	Revised UNITED programme treatment targets
25	UNITED Milestone activity Tracker September 2015
26	Updated DFID Logframe dated October 2015
27	Treatment data 2015
28	ADP documents
29	Accenture value for money strategy (screen shot)
30	A general Risk Management plan/framework - a brief description of the process by which risk is documented/managed.
31	Partner asset registers
32	Procurement Plan
33	Project budget and financial reports of spent to date broken down per year, per state and per activity

Documents Reviewed	
34	Treatment database – format and or full database
35	Training database
Project Technical Documents	
36	KAP Survey Zamfara and Katsina Aug 2014
36	Mapping methodology and data
38	NTD BCC strategy
39	HSS strengthening approach and tools used
40	PSM strengthening approach and tools used
41	MDA protocols, training and other tools used
Progress and review reports	
42	DFID Inception Review Jan 2014
43	DFID Annual Review Summary Dec 2014
44	DFID Annual Review 2015 (draft)
45	Inception report Oct - Dec 2013
46	Sightsavers Quarterly report to DFID Jan - Jun 2014
47	Sightsavers Quarterly report to DFID Jul - Sep 2014
48	MDA Report for Zamfara - Nov 2014
49	Sightsavers Quarterly report to DFID Oct 2014 - Jun 2015
50	Sightsavers Quarterly report to DFID Apr 2015 - Jun 2015
51	Crown Agents Report on Supportive Supervision and Monitoring Visit to LGAs
52	STH & SCH school age children strategy
53	TAG ToRs & meeting report
54	ISS documentation
55	UNITED Newsletters

Appendix 3 List of Key Informants interviewed

List of Key Informants interviewed		
Consortium members		
CBM	Angela Uyah	Finance Officer CBM
CBM	Adams Ibrhaim	Program Officer – CBM
Hands	Elisha Agagak	Program Officer – HANDS
Hands	Marian Kahasin	Finance Officer- HANDS
Crown Agent	Kenny Osasanga	Team leader
HKI	Dr Aliyu Mohammed	HKI Programme Manager
HKI	Dr Said	
MITOSATH	Jamila Iriogbe	Niger State Programme
MITOSATH	Dennys Abbck Adamn	Officer Programme Accountant
HPI	Dr Sani Jibrin	Director
HPI	Blessing Stephen	Technical Manager
DFID	Ruth Lawson	Senior Health Adviser
PMO	Safia Sands	Programme Director
PMO	Dr Ibrahim Nazaradden	Technical Manager- DFID NTD PMO
PMO/Sightsavers	Jumoke Alagbe	Institutional Funding Manager - WARO
Sightsavers	Dr Sunday Isiyaku	Country Director
Sightsavers UK	Tom Miller	NTD Programme Director
Sightsavers UK	Sam Turner	NTD Finance Coordinator
Sightsavers UK	Susan Walker	NTD Technical Advisor
States		
Katsina	Dr Samaila Mamman	Katsina State Coordinator
Katsina	?	Director Public Health
Katsina	Dr Samaila Mamman	NTD Coordinator
Katsina Musawa LGA	?	Yardanya Focus group
Katsina Musawa LGA	DR Mansir Yumusa	NTD Coordinator
Katsina Musawa LGA	Kabir Sani	Disease Control officer
Katsina Dusin- Ma LGA	Focus Group	Community
Katsina Dusin- Ma LGA	Rabiu Lawal	FLHFW Turare
Katsina Dusin- Ma LGA	Sale A Kandandani	Disease Control officer (RBM& NTD Focal point)
Katsina Dusin- Ma LGA	Hussain Nabara	LGA Logistician
Niger	Dr Sule Salisu	Director Public Health
Niger	Dr Sule Salisu	State Coordinator NTDs Programme
Niger Wushishi LGA	Abdullahi Mohammed	NTD Coordinator
Niger Habawoshi Kota	Abdullahi Aliyu Edo	FLHF
Niger Bankoli	Mohammed Baba Jirak	FLHF
Niger Agaie LGA	Yakubu Shwaibu	NTD Coordinator
Niger Wushishi	Focus Group	Bankogi Community
Niger AGAIE LGA	Focus Group	SHAMA WOSHI Community

List of Key Informants interviewed		
Zamfara	Dr. Habib	State Director of Public Health
Zamfara	Abdullah A Labbo	State National NTD Coordinator
Zamfara	Fabian Turkmen	Sightsavers Finance officer
Zamfara	Demas Shinggu	Sightsavers programme officer
Zamfara Tsafe LGA	Salia Saba	NTD coordinator
Zamfara Tsafe LGA	Hassan Mohammed	assistant NTD coordinator
Zamfara Kaura -Namada	Sheke Bawa Kaura	NTD coordinator
Zamfara Kaura -Namada	?	Director of Public health
Zamfara Tsafe LGA	Focus Group (men)	Bilbis community
Zamfara Tsafe LGA	Focus Group (women)	Bilbis community
Zamfara Tsafe LGA	Focus Group	Urban community
Zamfara Kaura -Namada	Focus Group (men)	Kurya Community
Zamfara Kaura -Namada	Focus Group (women)	Kurya Community
Federal Ministry of Health		
Federal Ministry of Health	Micheal Igbe	focal point for M&E NTDS & UNITED
Other		
Pfizer	Julie Jensen	Director Supply Chain, Corporate Responsibility

Appendix 4 a: example of KII interview Guide

Draft Key Informant Interview Guide for National Stakeholders

N.B. This is a guide – not all questions will be relevant and many of the sub-questions can be used as prompts.

Introduction:

I/we want to thank you for taking the time to meet with me/ us today to give us your insights and perspectives for the mid-term review of the Integrated Neglected Tropical Disease Control Programme (UNITED).

Scope and Focus of review and interview: In line with the Terms of Reference we will be exploring seven criteria that are essential to the achieving of the programme objectives: Relevance; Effectiveness; efficiency; Impact; sustainability; Scalability /replicability and Coherence and coordination.

The review will look at the four areas of enquiry outlined in the ToRS:

- 1 Are programme objectives are being met - through a review of performance against milestones and other planned activities?*
- 2 If there are gaps in implementation of the programme, and identify corrective measures to rectify the situation*
- 3 Document learnings for DFID, Sightsavers, members of the Consortium, Government and other stakeholders in NTD control activities.*
- 4 To assess relevant learning from the programme that can be applied to the wider health system*

Remind Interviewee that this is a review to look at the strengths of the programme that can be useful lessons learnt as well as identifying any weaknesses that need to be corrected in order for the programme to reach its objectives - not an evaluation of them.

All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. The report will however list all informants and their affiliations. If you prefer for your name not to appear in the list please advise the consultant.

Are there any questions or clarifications before we begin?

Name of Informant(s)

Institution/Organisation

Position

Date of Interview

Interviewer(s)

1. Relevance (to National NTD priorities) select which are appropriate for respondent, question a can be high level only and may be omitted
<i>a. In your opinion, what importance does NTD control policy have in the (National/ State / LGA) health system?</i>
Or for LGA: What is the level of importance for treating this neglected disease in your district?
<i>b. What are your current 5 top health needs or priorities? (for Director of public health/ state directors of public health / NTD coordinators)</i>
How does the UNITED NTD programme relate to the following aspects of your health system? (Select which are appropriate for respondent)
<ul style="list-style-type: none"> - Coordination and treatment between the NTDs - Treatment of other diseases - Other health programmes - Planning, Finance and reporting - Monitoring and evaluation - Disease surveillance - Drug supply, ordering, handling
2. Effectiveness
<i>a. Consortium model (specify diseases involved in the state/LGA)</i>
<ul style="list-style-type: none"> i. How was the control of NTDS funded and implemented in the State you work in before this UNITED Consortium approach? ii. What has changed in terms of e.g. training, reporting, problem –solving, disbursement of funding, timeliness of funding?
Can you describe the strengths of working with this Consortium and any particular lessons learnt that have led to a change in policy/strategy? Are there disadvantages? If so please describe them
<i>b. Where has Integration across diseases been most effective?</i>
<ul style="list-style-type: none"> i. Which MDA activities have been integrated in the State/ LGA you are working in? e.g. <ul style="list-style-type: none"> - ISS (integrated supportive supervision) and what indicators have been added in the ISS How are these being used or implemented? <ul style="list-style-type: none"> - Training (levels, competency, etc.) - advocacy - BCC /IEC activities - drug quantification - delivery/collection of drugs - timing of administration of drugs - reporting - M&E - other ii. In your opinion, what are the main factors that have helped to integrate the control of NTDS?

Are there things that could be done to improve the integration of NTD control?
<i>c. Impact of MDA (For national NTD staff to get perspectives on what they know about the programme)</i>
i. What has resulted from the UNITED NTD control programme since its inception?
<i>d. Key determinants for achievement of outputs /outcomes (primarily based on desk reviews, validation from some KIIs)</i>
i. What factors have contributed the most to the programme's achievements?
<i>e. Effectiveness through improved management process</i>
i. What (different) management processes and reporting systems have been developed and implemented by the consortium for integrated NTD control?
ii. In what way have the new process improved / in what way have the new processes complicated :
<ul style="list-style-type: none"> - reporting processes - Communication with implementation / consortium partners - Communication with external partners - Procurement forecasting / ordering/ delivery/distribution - Disseminating information and evidence for decision making - Other - In your opinion, what are the most efficient aspects of the UNITED NTD programme and why? - What are the least efficient aspects and why? - How could these be improved?
<i>f. Allocation of resources to maximise their use (N/A)</i>
4. Impact : implementation strategies/approaches has the project used to strengthen capacity of the coordination and implementation structures at the National, State, LGA and district level to facilitate effective and sustainable NTD control programmes
<ul style="list-style-type: none"> - What training has taken place to build capacity and at what levels? - In your opinion, have training and capacity building efforts improved competences in a sustainable way? - If not why not and what could be done to improve this?
a. Has capacity building and Health System Support been implemented at State level/LGA? And by whom? If so what kind?
b. What could be done to improve the health system strengthening?
c. What programme benefits have surprised you? Were there benefits outside of the MDA programme?
d. Have you noted any unintended <i>negative</i> effects of the integrated NTD programme to the health service/ community? If yes, how could these be avoided or mitigated against?
e. How have results from other States been communicated to you and have these results been used to change or improve processes- and if so how?
<i>Behaviour change communication & IEC</i>
The behaviour change and communication strategy has been developed and is being implemented
a. What were the major challenges in terms of implementing NTD control before the UNITED programme and its BCC strategy?
b. What are the changes in behaviour and perceptions towards NTDs that you have observed?

<ul style="list-style-type: none"> c. Are there any unintended <i>other positive</i> effects of the BCC strategy? d. Are there an unintended <i>negative</i> effects of the BCC strategy? e. If there are still challenges, how could these be addressed better?
<p>5. Sustainability</p>
<ul style="list-style-type: none"> a. Does the National NTD plan address the issue of functioning after external aid end? b. What is the State plan for programme sustainability when DFID funding ends? c. What does the SMOH need to do to ensure continuation of the treatment programmes when DFID funding ends? <ul style="list-style-type: none"> - Does the State/LGA have a budgetary line for NTDs? If not when does the budget line have to be established by in order to receive funds? - What could the LGA do to ensure continuation of the treatment programmes when DFID funding ends? d. What are the major factors at National/ State/ Local level that may impact financial and programmatic sustainability? e. What components of the UNITED NTD programme do you think will be the most sustainable from the delivery perspective? Can you explain why? f. What components of the UNITED NTD programme do you think will be the most sustainable from the beneficiary (user) perspective? Can you explain why?
<p>Drug Supply chain management</p>
<ul style="list-style-type: none"> a. Can you describe the procurement and delivery process for the drugs for the NTD programmes? <ul style="list-style-type: none"> - How has this changed with this UNITED programme (from the process before)? - What have been the major problems with the supply of drugs to the UNITED NTD programme since its inception? - Why was this? - Has the capacity of the FMOH drug supply chain management been strengthened now? How? - What areas still need to be strengthened? - What are the major challenges to be addressed regarding the drug supply chain management? - How have the State and LGA medical store management been strengthened? - What are the main challenges to be addressed at LGA level? - How will sustainability of effective supply chain management be ensured? - How will the NTD supply chain integrate into the national state system when external funding ends?
<p>b. Effective involvement of the community</p>
<p>How are community members (or representatives) involved in:</p> <ul style="list-style-type: none"> - Planning the NTD programme – timing of drug distribution, selection of CDDs, collection of drugs - Implementation collection of drugs, distribution - Monitoring - treatment data collection, reporting, monitoring for SAEs <p>- Feedback to the community of coverage, success etc.</p>
<p>6. Scalability/replicability</p>
<p>Dissemination of information regarding the project</p>
<ul style="list-style-type: none"> - Are there any aspects of the UNITED programme that have impacted other programmes positively? - Are there any aspects of the UNITED programme that have impacted other

programmes negatively?
Coordination mechanisms
<ul style="list-style-type: none"> - What coordination mechanisms are in place for the State stakeholders? - Has an NTD task force been set up? How often has it met – will it meet? - How does it coordinate / communicate with the national NTD steering committee?

Additional Questions

Additional Questions
<p>Are there any other issues that you would like to raise related to this project?</p> <p>Success, weakness and threats</p> <ul style="list-style-type: none"> - Can you give 2 things that have worked well in the UNITED programme – and why? - Can you give 2 things that did not work well and why? - What are the main strengths of The UNITED Consortium approach? - What are the main weaknesses of The UNITED Consortium approach? - What are the main threats that the programme faces and why? <p>Please give 1 recommendation for the improvement of at least 2 of the main programme activities:</p> <ul style="list-style-type: none"> - Behavioural change communication and coordination - Health system strengthening - Capacity building for drug supply chain management - The Mass Drug Administration

Appendix 4b Example of Focus Group Guide

Focus Group Guide for midterm evaluation about the UNITED programme's effectiveness

Instructions
Focus group should involve 6-10 participants
The moderator will help the group participate in a natural discussion. The moderator will be aided by a pre-prepared question guide that will be used to ask very general questions of the group -the question guide is only an outline of the major questions that will be asked of the group. It should be flexible enough to allow the group to take the discussion in any way it chooses, while providing enough structure and direction to stop the discussion moving away from the original topic to be studied.
An observer or note-taker will record key issues raised in the session, and other factors that may influence the interpretation of information by noting down the responses from the group, and observing and documenting any nonverbal messages that could indicate how a group is feeling about the topic under discussion. The observer may also help the moderator if necessary. She or he may point out questions that are not well explored; questions missed, or suggest areas that could be investigated. The observer should not be especially obvious to the group, but needs to be able to communicate with the moderator if required.
Sampling Given the time limitations for both preparation and conduction of the focus groups, We will use "purposive" or "convenience" sampling, meaning that we select those members of the community who we think will the best information.
Translation from English to Hausa as needed
Key questions - this need to be revised /rewritten as the Focus Groups discussions take place but the main focus of the questions is to determine: a) The relevance of the programme to the health needs of the target beneficiaries b) The extent to which community members are involved in the programme planning, implementation and monitoring
Introduction: Begin the discussion with a welcome and introduction, followed by an overview of your project, an introduction to the note-taker, moderator's role, ground rules, comments on confidentiality, and discussion questions. Ground rules include respecting others' opinions, ensuring equal group participation, and getting closure on each question before moving on. Finally, it is very important to stress to participants that there are no right or wrong answers. In addition to providing participants with information about the focus group, also assure them that you will not use their names or any other identifiable information in any publications or reports that you write. Remember to stay neutral. Avoid using positive verbal responses such as "correct" or "that's good."

DRAFT FOCUS GROUP DISCUSSION GUIDE	
Group Type	
Interviewer Name	
Community Name	
LGA Name	
State Name	
Date of Interview	
<p><i>Good morning, we are here from ... and We are interested in talking to you about health in your community. Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. You probably prefer that your comments not be repeated to people outside of this group. Please treat others in the group as you want to be treated by not telling anyone about what you hear in this discussion today. Let's start by going around the circle and having each person introduce Him/herself. (Members of the team should also introduce themselves and describe each of their roles.)</i></p>	
1. Health needs	
- What do you do to keep you and your family healthy?	
- Can you describe some of the main health problems that affect you and the community?	
- What about the main health problems your children suffer from – are they the same?	
- Which are the (3-4) most important health issues for you and this community?	
2.. The UNITED programme	
What do you know about the following diseases?	
- River blindness (how important is this disease in this community?)	
- Lymphatic Filariasis (how important is this disease in this community?)	
- Schistosomiasis (how important is this disease in this community?)	
- Trachoma (how important is this disease in this community?)	
- Intestinal worms (STHs) (how important is this disease in this community?)	
- Can you explain how are these diseases treated?	
- Have you noticed an improvement in any of treatment of these diseases recently? (Why, what changed?)	
- What do you know about the about the Mass Drug treatment programme (UNITED) for these diseases?	
- Was anyone from your community was involved in planning the MDA treatment programmes?	
- Who are they? How were they selected ...	

- | |
|---|
| - Is anyone from your community involved in the distribution of the drugs for the diseases? |
| - Who are they? How were they selected? Do you think they are doing a good job? |
| - What other activities in this programme are community members involved in? (Monitoring). |
| - Any other questions or points you would like to raise? |

Thank you all for participating in this discussion

Appendix 5 - Mid Term Review of the DFID Funded Northern Nigeria Integrated NTD Control Programme

Background

Neglected Tropical Diseases (NTDs) are a diverse group of diseases with distinct characteristics that thrive mainly among the poorest populations in low income countries especially in Africa, Asia and the Americas. Among all of the African nations, Nigeria has the highest number of people infected with NTDs. To address the problem the Nigerian government has developed an NTD Master Plan targeting the control/elimination of NTDs. However, some of the seven common NTDs can be controlled or eliminated with preventive chemotherapy using cost effective approaches.

The UK Department for International Development (DFID) in buying into the national plan has committed resources to the integrated control of seven NTDs in Northern Nigeria. The programme spans over a period of 4 years (Oct 2013 to Sept 2017). The first 3 years will be fully funded by DFID while it is expected that the State governments take over in year 4. The initial budget was £10.9m but with the contract amendment in April, 2014 the funding has increased to £11.6m.

Initially the support was to Kano, Katsina, and Zamfara States, however, the prevalence of the diseases in the three states was lower than estimated thereby resulting in savings for expansion to additional states. As a result of the contract amendment was recently approved by DFID, the programme was expanded to two more states: Niger and Kaduna. The programme is now covering a population of up to 27 million people and is expected to deliver 112 million treatments over the four year period.

1.1 Project Name: DFID-UNITED; Northern Nigeria Integrated NTD Control Programme

1.2 Project Duration: October 2013 - September 2017

1.3 Project Budget: £11.6 Million

1.4 Project Partners: NGOs (Sightsavers, Helen Keller International, CBM, MITOSATH and the Carter Center), academic partners (Liverpool School of Tropical Medicine, Centre for Neglected Tropical Diseases, London Centre for NTD Research); private sector partners (Health Partners Initiative) and private sector suppliers (Accenture Development Partners and Crown Agents)

1.5 Key Stakeholders: The Federal Ministry of Health (FMOH), State Ministry of Health (SMOH), States (Kano, Zamfara, Katsina, Niger and Kaduna).

1.6 Project design: Sightsavers is leading a consortium of partners made up of NGOs, academic partners, private sector partners and private sector suppliers as mentioned above, to implement the DFID-UNITED; Integrated NTD Control

Programme.

There are five key activities;-

- Mapping of NTDs,
- Behavioral change communication and Coordination,
- Health System strengthening,
- Capacity building for drug supply chain management
- Mass drug administration

The NGO partners in collaboration with the states ministry of health are responsible for the implementation of mass drug administration. HKI in addition to its role in supporting the implementation of MDA is responsible for the development of the Behavior Change Communication (BCC) strategy and communication materials as well as monitoring and assessing the impact of the communication materials.

The academic partners support the monitoring and evaluation activities of the programme to ensure that programme implementation is evidence based and in conformity with international best practice.

The private sector partner, Health Partners International is responsible for health system strengthening while Crown Agents in addition to procurement and drug delivery is responsible for building capacity for drug supply chain management.

To support with scale-up from one to five States, Sightsavers has engaged a private sector partner, Accenture Development Partners (ADP) to support with the establishment of governance structures and streamlining of the reporting processes to ensure the programme management is effective.

Furthermore, the programme comprises of three phases;

- Phase 1: the inception phase, when programme management structures and systems were set up.
- Phase 2: the pilot phase, when mass drug administration was piloted in Zamfara
- Phase 3 and Scale, when mass drug administration will be scaled up to four additional states of Kaduna, Kano, Katsina, Niger

The pilot phase of the project started in Zamfara State in October 2013 and ended in September 2014. Despite numerous challenges including a strike by customs officers which delayed drug clearance at the port of entry and disease outbreak, 4.4million NTD treatments were delivered and 2.8million people were reached.

Over the last eight months, the Sightsavers led-UNITED consortium has been supporting set-up in Kano and Katsina as part of the scale up of the programme activities and in the new states of Niger and Kaduna that were included in May, 2015. The programme was affected by the presidential elections that took place in May as activities were either put on hold or scaled down due to apprehension around potential instability and violence. On a good note, the elections passed relatively peacefully and the political transition between presidential candidates was smooth.

ADP are also supporting with a value for money strategy for the programme as well as planning for exit under Phase 4.

1.7 Project Goal:

The goal is to reduce the prevalence, and interrupt the transmission of seven NTDs (Oncho, Lymphatic Filariasis, Trachoma, Schistosomiasis, Soil Transmitted Helminthiasis (whip worm, round worm and hook worm) which are amenable to preventive chemotherapy. The programme aims to strengthen the health system including drug supply chain management to deliver drugs to those in need.

1.8 Project Area: Map of Nigeria Showing the Project Area



Table 1: Disease Prevalence in each of the States

S/No	State	Total Number of LGAs	Number of LGAs Endemic for the diseases				
			Oncho	LF	Schisto	STH	Trachoma
	Kaduna	16	18	14	4	0	
	Kano	18	44	23	0	4	
	Katsina	0	30	18	1	6	
	Niger	21	18	23	6	1	
	Zamfara	6	14	14	0	5	

1.9 Project Objectives:

- Programme aims to strengthen the health system including drug supply chain management to deliver drugs to those in need through the following key areas.
- To operate MDA at scale in Zamfara (and continue existing NTD programmes in Kano, Katsina, Kaduna, Jigawa and Niger States).
- To set up processes to gather evidence for decision making (including support mechanisms to strengthen health management information system).
- To deliver a range of health system strengthening technical support to the MoH at federal and state levels in Kaduna, Kano, Katsina, Niger and Zamfara (including drug supply chain management).
- To operate integrated MDA at scale in Zamfara, Kaduna, Kano, Katsina and Niger (and continue existing programme in Jigawa)
- To support effective BCC/IEC campaigns in Zamfara, Kano, Katsina, Kaduna and Niger.
- To improve coordination with all relevant stakeholders in Kano, Katsina, Zamfara, Kaduna and Niger States.
- To improve evidence for decision making (including support mechanisms to strengthen health management information system)
- To deliver a robust management approach from the PMO driving economy throughout the programme cycle

1.10 Project Outputs:

- To deliver 112 million treatments
- To reach 27 million people

Purpose of Evaluation

- To assess programme performance against milestones and other planned activities to ascertain if programme objectives are being met.
- To explore gaps in implementation to ensure corrective measures are put in place.
- To generate learning for DFID, Sightsavers, members of the Consortium, Government and other stakeholders in NTD control activities.
- To assess the benefits of the programme to the overall health system.

Evaluation Criteria

Relevance

- How is the programme addressing the National NTD priorities?
- How relevant is the programme to the health needs of the target beneficiaries?

Effectiveness

- What is the value added in terms of using the Consortium model as opposed to parallel donor - NGDO funding streams for the different states?
- Which MDA activities are integrated and how does that promote cost effectiveness?
- What are the key determinants for the achievement of outputs and outcomes?

- If the outputs/outcomes are not achieved, what are the reasons?
- How have the management processes and reporting systems developed ensured the effectiveness of the programme?
 - Is evidence from research and M&E activities being used to review programme performance or direction?
 - To what extent has the Behavior Change Communication strategy been successfully implemented?
 - Efficiency
 - Is there evidence of inefficiencies in the way the programme is being implemented, particularly the allocation of resources (human, material and financial)? If so, how might these be improved?
 - What mechanisms are in place to ensure value for money?
 - What internal control mechanisms does the consortium have in place to ensure funds received are well managed?
 - What measures are in place to improve partners' skills in programme and finance management?
 - Impact
 - What processes are in place to ensure long term changes in terms of strengthening health systems and improving access to health care services?
 - Are there any unintended positive or negative effects of the programme?

Sustainability

- To what extent, has the NTDs programme developed strategies for programmatic sustainability? E.g. to what extent has the capacity of the FMOH been built in the areas of drug supply chain management?
- What are the major factors at the Local, State and National Government system level which influence, or may influence, the financial and programmatic sustainability of the programme?
- How robust is the approach being used to develop the exit strategy?
- To what extent are community members or their representatives involved in programme planning, implementation and monitoring?

Scalability/Replicability

- What processes or initiatives are there in place to generate the evidence base for scalability/replicability?
- What are the strategies implemented to document, communicate and disseminate information about the project to broader stakeholders?
- How have the lessons from the pilot phase been used in scaling up activities in the additional states?
- Coherence/Coordination
- To what extent are the objectives, approaches and design of the intervention complementary or contradictory, considering both internal and external factors?
- What coordination mechanisms are in place and how well are they functioning?
- How well integrated is the programme into other health and education programmes in the States, particularly those which are DFID and USAID funded?

Review Team

The evaluation will be conducted by an external consultant, or evaluation team which will be selected through direct approaches to recommended experts. The consultant/s or firm will have demonstrated competence in having undertaken similar work before, including experience in programme design and management, planning, monitoring and evaluation.

The lead evaluator will have the following core competencies as a minimum; international public health specialist experience preferably in NTDs, possess projects/programme analysis, report writing, oral presentation skills. S/he should have extensive experience in conducting medium scale evaluations as well as a good understanding of the Nigerian health system.

The evaluator/evaluation team will work closely with an evaluation working group. The role of this group (or their representatives) will include validation of strategic information, issuing of relevant directives or endorsement of necessary proposals during the course of the exercise and coordination of local logistics. The working group will include the following: Sightsavers, Nigeria Country Director, Head of PMO, Nigeria Integrated NTD Programme, Evaluation Advisor, Senior Global Impact Advisor, Head of Institutional Funding, Institutional Funding Manager and West Africa Regional Office.

Methodology

The detailed methodology will be developed by the evaluator/evaluation team based on the objectives of the evaluation. The evaluator/evaluation team would ensure that the review is carried out in a manner that fully engages all stakeholders and partners in participatory approaches. The following broad activities will be expected of the team.

Desk review and preliminary analysis of available data and reports with particular attention to project document, annual reports, work plan, treatment database, asset register, partner reports and procurement status update.
Undertake field visits to 3 states. The selection will ensure that states at different levels of programme implementation are covered.

Zamfara State: - The programme commenced in 1996 with support from Sightsavers and later with additional support from APOC. It has a well-established CDI platform and a fully scaled up NTD programme covering all endemic diseases since 2010.

Katsina State: - have no experience of CDI, and is therefore commencing MDA for the first time.

Kano State: - have existing CDI platform, and have enjoyed good support from CBM. They are scaling up treatment for more NTDs, and to additional local government areas.

Kaduna and Niger are the new states coming on board

Kaduna has a well-established CDI platform and enjoyed good support from Sightsavers; Niger State have enjoyed minimal support. Both states are scaling up to cover additional local government areas and more diseases.

Niger state have existing CDI platform but in the past had minimal support to NTD control activities

The selection of Zamfara, Katsina and Niger States for field visit is recommended. This suggestion has been made as Sightsavers are keen to document the learning that has been built into the new phases of the project.

Hold discussion with a cross-section of beneficiaries and stakeholders to obtain beneficiary feedback. These will include community members, SMOH staff, health workers at the LGA and frontline health facilities, Consortium members and NTD Division FMOH

Do a SWOT analysis of the programme and partnership.

Field visit

Reference Material
Project Proposal
Programme organogram
Programme Reports
Procurement plan
Partner contracts
Programme work plan
BCC Strategy
Report of KAP survey
Asset Registers
Minutes of meetings
Trip reports

Timeframes

Expected Number of Days Evaluation Team Input

The evaluation will be carried out over the months November 2015 - January 2016. The methodology development and Inception Report will be done in November; field work is planned during early December and report writing late December to early January. Submission of a draft Final Report will be due by 11th January 2016. The final report should be submitted to Sightsavers not later than 26th January 2016.

A detailed workplan and allocation of days against the work plan will be shared with the consultant at the start of the assignment.

Outputs/ Deliverables

INCEPTION REPORT

The inception report should be available to Sightsavers within five working days of evaluation commencement. Feedback will be provided within ten days following acknowledged receipt of inception report. Field work should not commence until an agreement on the report has been made.

DRAFT REPORT

A draft report (using the appropriate reporting format and not more than 40 pages including executive summary and excluding annexes) should be submitted to the evaluation working group. Sightsavers will provide feedback on the draft version to the evaluation team within 3 weeks after receiving the draft report.

FINAL REPORT

The final report should be submitted within 5 working days after receiving the feedback from Sightsavers on the draft report. The appropriate reporting format (see section 8 below) will be made available to the winning bid at the commencement of this contract.

DATA SETS

The evaluation team will be expected to submit complete data sets (in Access/ Excel/Word) of all the quantitative data as well as the original transcribed qualitative data gathered during the exercise. These data sets should be provided at the time of submission of the final report.

SUMMARY FINDINGS

On submission of the final report, the team is expected to submit a PowerPoint presentation (maximum 12 slides), summarizing the methodology, challenges faced, key findings under each of the evaluation criteria and main recommendations.

REPORTING FORMAT

The report will focus on:

- Findings of the review in relation to the key review questions and objectives of the mid-term review
- Key learning points around the implementation programme
- Recommendations on the next steps/action for the programme

The format should conform to the following:

- Table of Contents
- Executive Summary
- Background
- Purpose of review
- Methodology
- Constraints/Limitations
- Results
- Recommendations
- *Identify any emerging lessons*
- *Propose how these will feed into the programme*

- Learning
- Conclusions
- Appendices





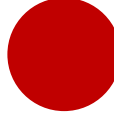

Please note that penalties up to 10% of agreed fees may be imposed for noncompliance with the requirements 7.1 to 7.4 and reporting format provided.

Administrative/Logistical support

The programme will be responsible for all travel arrangements, accommodation and feeding of the review team.

The Sightsavers, UK travel team and the programme management office will make all logistic and travel arrangements for the team.

Appendix 6 - Evaluation Criteria Rating

	Excellent	<p>There is strong evidence that the project fully meets all or almost meets all aspects of the evaluation criterion under consideration. The findings indicate <u>excellent and exemplary</u> achievement/progress/attainment.</p> <p>This is a reference for highly effective practice and an Action Plan for positive learning should be formulated.</p>
	Satisfactory	<p>There is strong evidence that the project mostly meets the aspects of the evaluation criterion under consideration. The situation is considered <u>satisfactory, but there is room for some improvements</u>. There is need for a management response to address the issues which are not met.</p> <p>An Action Plan for adjustments should be formulated to address any issues. Evaluation findings are potentially a reference for effective practice.</p>
	Attention	<p>There is strong evidence that the project only partially meets the aspects of the evaluation criterion under consideration. There are <u>issues which need to be addressed and improvements are necessary</u> under this criterion.</p> <p>Adaptation or redesign may be required and a clear Action Plan needs to be formulated.</p>
	Caution	<p>There is strong evidence that the project does not meet the main aspects of the evaluation criterion under review. There are <u>significant issues which need to be addressed</u> under this criterion.</p> <p>Adaptation or redesign is required and a strong and clear Action Plan needs to be formulated. Evaluation findings are a reference for learning from failure.</p>
	Problematic	<p>There is strong evidence that the project does not meet the evaluation criterion under consideration and is performing very poorly. There are <u>serious deficiencies</u> in the project under this criterion.</p> <p>There is need for a strong and clear management response to address these issues. Evaluation findings are definitely a reference for learning from failure</p>
	Not Sufficient Evidence	<p>There is not sufficient evidence to rate the project against the criterion under consideration.</p> <p>The project needs to seriously address the inability to provide evidence for this evaluation criterion.</p>