

GiveWell Annual Review

Year 1

January 2017 – March 2018 (15 months)



<p>Name of grant holder: Sightsavers</p>	<p>Project title:</p> <p>Delivering schistosomiasis and soil transmitted helminths MDA in: DRC (Ituri Nord) Nigeria (Kogi, Kebbi, Kwara and Sokoto states), Guinea Bissau and Guinea Conakry (3 districts in Forest region).</p> <p>Delivering an integrated NTD programme for soil transmitted helminths, schistosomiasis, river blindness and lymphatic filariasis in Nigeria's Benue state.</p> <p>Building the evidence base for the WASH SBCC as a MDA synergy in control transmission of SCH and STH in the West, North-West and South-West Regions of Cameroon.</p>
<p>Project Value:</p> <p>Wishlist 1: US\$ 2,950,000</p> <p>Wishlist 2: US\$ 2,500,000</p>	<p>Start Date:</p> <p>Wishlist 1: 1 January 2017</p> <p>Wishlist 2: 1 January 2018</p>
<p>Project expenditure year 1:</p> <p>\$1,451,271</p>	<p>End Date:</p> <p>Wishlist 1: 31 December 2018 (2019 for Cameroon)</p> <p>Wishlist 2: 31 December 2019</p>

Overview of schistosomiasis and soil transmitted helminths

Neglected tropical diseases (NTDs) affect more than a billion of the world's poorest people. Sightsavers, with funding from the GiveWell, is helping to control and eliminate two significant NTDs: schistosomiasis (SCH) and soil transmitted helminths (STH), which cause significant health issues and pre-mature death. The global burden of STH is about 5.27 million disability-adjusted life years (DALYs)¹ with an estimated 200,000 people dying from SCH each year².

Along with three other NTDs, trachoma, onchocerciasis and lymphatic filariasis, the spread of SCH and STH can be controlled through large-scale treatment programmes, known as preventive chemotherapy. The process is known as mass drug administration (MDA) where treatment is given to whole populations regardless of whether an individual has been diagnosed with the disease or not. The most cost effective approach to reach infected individuals is to treat the entire at risk population without individual diagnosis.³

Annual treatment with praziquantel, donated by pharmaceutical company Merck, is the recommendation in areas at high risk of re-infection with SCH. This also helps to reduce the severity of symptoms in chronic sufferers. Where risk is lower, the recommended treatment frequency is less; e.g. once every 2 or once every 3 years. Although treatment targets school-aged children, in some areas adults, such as fisher folks, are at risk. Similarly, STH is treated through a single dose of a deworming medicine; either albendazole, donated by GlaxoSmithKline and used to treat NTD lymphatic filariasis, or mebendazole donated by Johnson & Johnson. The recommendation is to treat all at-risk people in an endemic area, specifically preschool-aged children, school-aged children, women of childbearing age and adults in certain high-risk occupations once or twice per year.

As both treatment programmes primarily target school age children, deworming (SCH and STH) can be set within school health programmes. The medicines are administrable by trained teachers or trained community volunteers. Globally, in 2015, 31.9 million school-aged children in areas co-endemic with SCH and STH were treated for both diseases, while 68.2 million were treated with albendazole (or mebendazole) only, and 16.4 million were treated with praziquantel only.⁴

Sightsavers approach for SCH and STH

Sightsavers has been preventing and treating NTDs since 1953. Historically we focused on those diseases that cause blindness i.e. trachoma and onchocerciasis. However, more recently our integrated approach supports treatments for all five NTDs, Oncho, trachoma, LF, SCH, STH) that require preventive chemotherapy. We recorded our first treatments for SCH and STH in 2011, although indirectly we have supported STH in programme areas that are co-endemic with Lymphatic filariasis and STH since albendazole, the drug used for STH, is part of the drug package of Ivermectin + albendazole for LF MDA.

¹ WHO (2016). Weekly Epidemiological Record, No. 49/50, apps.who.int/iris/bitstream/10665/251908/1/WER9149_50.pdf?ua=1 (accessed 27 February 2017)

² WHO (2017). Schistosomiasis Fact Sheet, www.who.int/mediacentre/factsheets/fs115/en/ (accessed 27 February 2017)

³ Guideline: preventive chemotherapy to control soil-transmitted helminth infections in at-risk population groups. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO

⁴ WHO (2016). Weekly Epidemiological Record, No. 49/50, apps.who.int/iris/bitstream/10665/251908/1/WER9149_50.pdf?ua=1 (accessed 27 February 2017)

Our capacity and policy

In line with WHO guidelines, Sightsavers supports endemic countries to develop an 'integrated' NTD programme that brings together a number of disease-specific programmes; the approach helps achieve cost alignment efficiencies and leveraging of delivery capacity. We also promote cross-sector coordination with non-drug based interventions, such as health education, immunisation programmes and Water Sanitation and Hygiene initiatives.

While WHO recommends that STH treatments also be offered to pre-school age children and women of childbearing age (WCA), Sightsavers currently considers only the SAC population for the planning and targeting of ALB or MBD. This is true for both ALB treatments provided through community-based LF treatments as well as stand-alone deworming in schools. This is because, 1) as a process indicator for measuring control of STH and SCH morbidity, more than 75% of the SAC should be covered, and 2) STH and SCH treatments are primarily only donated for SAC albeit that WHO has made occasional exceptions.

Partnerships - with Government and MOHs

Our primary partner in all programmes is the national government. Our approach is to enhance their capacity for SCH and STH control by providing technical expertise, whilst advocating, lobbying, and maximizing stakeholder support to create a supportive policy environment that promotes, where feasible, SCH and STH control and elimination as a public Health problem... We work within government systems and structures to deliver high quality SCH and STH control approaches in targeted districts and at national level so that governments can continue to deliver services independently beyond the scope and timeframe of donor support.

Integrated approach

Sightsavers takes a practical approach to integration. On the ground, we look at how we can deliver SCH and STH treatments to those that need them with the ultimate goal of achieving control and elimination whilst ensuring that services are within the local health systems. MDA and WASH activities are examples of areas where recipients benefit from an integrated approach. Sightsavers works to achieve integration of MDA and WASH services by getting previously autonomous programs to participate in joint planning, budgeting, training, coordinated delivery platforms, monitoring and evaluation cycles, and even shared staffing when appropriate e.g. integrated data manager. We guide integration with the expectation and experience that activities across multiple individual programs improve the efficiency with which funds are spent and services scaled-up.

Include STH treatments through LF

Although we are able to isolate and deliver disease specific programmes and isolate costs for the delivery of treatments for SCH and STH, we also acknowledge that LF elimination programmes distributing Ivermectin in combination with albendazole are also treating STH. However, as LF programmes are quickly achieving elimination milestones and stopping MDA, SCH and STH MDAs need to be maintained in the schools and other routine or longer term health services; e.g. school based eye examination, onchocerciasis MDA.

It is increasingly recognised community-based approaches for MDA might have a greater impact on the burden of STH and SCH in SCA.⁵ This is because there is often a benefit to treating at-risk adults that might prolong transmission in SAC. In addition, community based MDA enables programmes to reach a higher coverage among SAC where school attendance rates are low.⁶ The importance of ongoing monitoring and identifying the species and intensity of infection among various age groups is important given that hookworm infection seems to respond poorly or sub-optimally to ALB and adults can be reservoirs for reinfection in children.

Monitoring and evaluation; QSATs, TCS, impact surveys

After a number of deworming rounds with good coverage, >75% coverage of SAC, parasitological indicators are collected at sentinel sites to show whether reduction in the prevalence and intensity of infection in the target population has been achieved. These indicators are used to assess whether SCH or STH has been eliminated as a public health problem (the elimination of SCH and STH as a public health risk equates to <1% moderate to heavy intensity (MHI) of infection in high-risk groups). Unfortunately, it is not possible to predict whether reductions will be permanent or whether infection will return to original levels soon after the interruption of regular treatment even at moderate prevalence levels. Despite intense MDA strategies, a rapid return to high levels of prevalence can occur if the drug intervention is interrupted. Therefore, annual sentinel site monitoring activities should continue, supported by Ministries of Health, particularly when reducing the frequency of drug administration. If sentinel site monitoring shows that prevalence remains low for 4 years, despite the reduction in frequency of drug administration, a further reduction is possible.⁷

To support programs in the achievement of these milestones, Sightsavers provides additional monitoring and evaluation elements to its programs, including a programme portal, quality standards tools, as well as robust data collection and reporting processes and tools that are further described in the M&E Section below.

Summary of progress since January 2017

GiveWell funded projects have supported the distribution of over 5.6 million deworming treatments to 4.6 million school aged children across four countries.

Kebbi, Kogi, Kwara and Sokoto states in Nigeria and DRC attained the impressive geographic and therapeutic coverage rates of over 90% for SCH and 80% for STH. These achievements came about through an effective scale up in the delivery of outputs:

We reinforced the capacity of health professionals and members of the community to undertake MDA through training. Of the 1,917 health professionals, 15,393 teachers and 11,244-community drug distributors (CDDs) targeted, 5,144, 15,428 and 14,821 respectively were trained, deployed and supervised.

⁵ <https://www.sciencedirect.com/science/article/pii/S240567311630040X>

⁶

https://journals.lww.com/coinfectediseases/Fulltext/2017/10000/Prospects_for_elimination_of_soil_transmitted.7.aspx

⁷ Helminth control in school age children: a guide for managers of control programmes - 2nd ed. World Health Organization 2011

By so doing:

- **4,645,921 school aged children were treated for SCH and/or STH⁸**
- Three treatment coverage surveys are complete, with the final two for 2017 going ahead in Guinea Bissau and Benue state Nigeria during May 2018
- Support has been given to Ministries of Health to coordinate 41 advocacy meetings, whilst supporting sub national level administrations to fully implement national NTD elimination strategies, making sure that each project's specific intervention aligned to each countries' national elimination agenda.
- Advocacy; value for money; equity, gender and social inclusion; sustainability and capacity building issues are set within project planning and management cycles through a crosscutting planning and implementation process.

Building the Evidence for National Programmes

In Guinea Bissau, the project supported the Ministry of Health with a nationwide re-mapping (impact survey) of SCH and STH in 122 schools, across 11 health regions, from November 2017 to February 2018. The objective of the re-mapping was to re-evaluate the SCH and STH prevalence by region, as results from the 2005 baseline were widely agreed to be out of date. Inaugural SCH and STH MDA treatments within WHO guidelines followed the results of the re-mapping results. Further, a treatment strategy by region based on recorded prevalence is available.

The project in Cameroon also included an impact survey for SCH and STH across the West, North-West and South-West regions. Survey activities began in February 2018 after the finalisation of the protocol, with data collection due to finish in May.

Results from the surveys in Guinea Bissau and Cameroon has/will allow the respective Ministries of Health to revise their SCH and STH control/elimination strategies in line with WHO protocol.

Meeting Our Challenges

Supply chain issues have been a common occurrence throughout our implementing countries. These have ranged from delays in international deliveries, consignments held in ports on bureaucratic charges and regional delivery issues. Albeit late, drugs reached the beneficiary children with all the evidence pointing to good coverage.

Due in part to supply chain issues and in part to the development of impact survey protocols, this 'year 1' report covers the 15 month period (January 2017 – March 2018). Our 'year 2' annual report will therefore cover the period April 2018 – March 2019. Subsequent reports will continue to cover an April – March reporting period, thereby avoiding all possibility of double counting.

⁸ Children receiving at least one deworming treatment: our figures make the assumption that the larger of the two treatment numbers (SCH vs STH) is the total number of children receiving treatment and that all children attending school are aged between 5 -15.

Table of outputs – all countries MDA

Output	Indicator	Year 1 Jan 2017 - Mar 2018	
		Milestone	Achievement ⁹
1. Train health workers, teachers and community members to deliver SCH/STH MDA to schools and endemic communities.	1.1 Number of teachers trained on SCH/STH MDA.	15,393	15,428
	1.2 Number of health workers trained on SCH/STH MDA.	1,917	5,144
	1.3 Number of Community Drug Distributors (CDDs) trained on SCH/STH MDA.	11,244	14,821
	1.4 Number of schools training at least one classroom teacher on school MDA.	12,613	11,862 Does not include Guinea Bissau data
2. Treat school-aged children between 5-15 years for STH and for SCH through Mass Drug Administration (MDA).	2.1 Number of school aged children treated for STH via MDA with albendazole.	1,082,864	1,058,431
	2.2 Number of school aged children treated for SCH via MDA with praziquantel.	4,768,100	4,645,921
	2.3 Number of treatment coverage surveys conducted with data disaggregated by age group and gender and school attendance.	5	3 2 pending in May 2018
3. Ministry of Health coordinates and supports targeted regions/districts to implement the National NTD Plan with focus on SCH and STH.	3.1 Number of advocacy meetings conducted with stakeholders on SCH/STH Interventions.	32	41
4. Data on hand washing and latrine facilities in schools available at operational level.	4.1 Proportion of health zones/districts/LGAs reporting on 6 key WASH indicators	29%	*0%

*The project gathered data on the number of districts reporting WASH indicators. None as yet are doing so. Our future work in this areas will continue to encourage cross-sectoral coordination and advocate for a complementary approach.

⁹ Coverage rates reported by CDDs

Adult treatments

We have not targeted any adults for STH and SCH treatments in any GiveWell funded project in year one. MDA in all countries was targeted at school aged children, however, some children are not aware of their exact age. This means we cannot state categorically that some older children were not treated if they were attending school on the day of MDA.

In some instances in Nigeria, during community MDA some people over 15 will have received treatments. We have not included them in our targets or actuals.

Output and outcome narrative

Training output targets were exceeded across the programme, with particular success in the number of health workers engaged in the programme. In many cases, this was due to an increased need for community MDA in order to ensure coverage where schools were closed or had low enrolment/attendance. We are also able to take learning from year one and use this knowledge to update our targets for year two, for example helping the Ministries of Education update their regional lists of schools.

All individual projects exceeded their treatment targets other than Benue state Nigeria, where targets could not be met. The fact that all but one project achieved output targets, especially in areas we had not previously conducted SCH and STH MDA, is a credit to the collaboration between Sightsavers staff and their respective Ministries of Health.

Benue's performance was due in part to conflict between armed groups of herdsmen and farmers in a number of districts within Benue. The insecurity in these areas led to a number of schools delaying the start of term until the combat had subsided, thus delaying MDA. Some districts in Benue continue to be affected by insecurity and where schools did not reopen, a community approach had to be taken. MDA was none the less completed, but despite hard work to mitigate the impact of school closures, fewer children received treatments than targeted.

Due to the issues in Benue, our treatment outputs are down on target by 3% for SCH and 2% for STH.

Our country based therapeutic coverage rates (outcomes) exceed attainment of the World Health Organisation target to reach 75% at risk SAC in all projects with the exception of Benue. Sustained treatments with coverage over 75% will, over time and with complementary strategies, lead to a reduction in the prevalence and intensity of SCH and STH amongst school age children.

Some treatment coverage rates are inflated due to inaccurate population census data. Sightsavers will continue to raise this issue with the relevant stakeholders and advocate for a more accurate denominator. To combat this, treatment coverage surveys are conducted to give us another measurement with which to measure the effectiveness of our MDA programmes.

Knowledge gained from the surveys conducted in Guinea Bissau and ongoing in Cameroon will allow the respective Ministries of Health to target SCH and STH interventions appropriately, optimise the use of drugs and positively contributes to their NTD control and elimination strategies.

GiveWell has had a transformative effect on our ability to deliver deworming treatments for children at scale. We are delighted that in year 1, with GiveWell directed funds, over 4.6 million school aged children have received deworming treatment. Without GiveWell's recommendation we could not have achieved this.

Everyone at Sightsavers is hugely grateful for GiveWell's continued support for this work; our country offices, our partners, and ultimately our beneficiaries, have all felt the impact of your contribution.

Monitoring and evaluation

Sightsavers Monitoring and Evaluation (M&E) systems are constantly evolving to meet programmatic needs; below is a description of the M&E structure as it currently stands, with M&E tools highlights in **bold**.

The NTD directorate has an M&E team, complementing a central Programme Systems and Monitoring Team (PSMT) with field based activities. The NTD M&E team provide guidance during project development, planning, and implementation. The Global leads provide disease specific technical guidance such as trachoma, oncho/LF and SCH/STH, with regional and country office M&E teams play cross cutting roles and cover all PCT-NTDs.

M&E roles within the NTD Directorate include, but are not exclusive to:

- Providing technical guidance for **disease mapping to establish baseline** prior to project implementation, including developing protocols, sampling methods and interpreting results in order to develop a treatment strategy;
- Identifying **Logical framework indicators** that can be used as a programme management tool to effectively track progress toward project outcomes and impact;
- Guiding country offices in developing **data collection logs** as a means of documenting from the logical framework who measures what, when and how, and how they communicate the information raised;

The NTD M&E team also coordinates **Treatment Coverage Surveys (TCS)** after MDA, a key indicator as to how successful a round of MDA has been. Treatment coverage surveys sample the 'at risk' populations who should have been involved in the MDA campaigns and ask if they a) were asked to take medication and b) accepted the medication. These results are collected alongside demographic information, using by specific tools such as the Washington Group Short Set questions on disability, as well as other quality indicators. The demographics and quality assessments are then be used to ascertain if there is potential systematic exclusion within the MDA campaign, and if so, what can be done to overcome it in the next round of MDA.

As well as mapping at the beginning of the project, the M&E team also tracks progress towards elimination via **impact surveys** at strategic points within the national programmes. Examples of such impact surveys include those in Guinea Bissau and Cameroon in year one of the GiveWell project. Similarly, to the baseline mapping, the M&E team are involved in the protocol development and survey design, training of surveyors and interpretation of results.

As well as the global NTD team, we are expanding our M&E capacity in country by employing M&E Officers based in implementing regions.

The NTD team are backed-up centrally by the Sightsavers PSMT team, who oversee all monitoring within Sightsavers. Team members are based in the UK Head Office, as well as in West and East Africa Regional Offices. Their role includes supporting programme staff with proposal and project development, developing programme monitoring guidance and tools, facilitating the input and finalisation of project and organisational data and undertaking spot checks of programme data.

PSMT use two main programme information systems to assist in programme monitoring: Quality Standards and the Programme Portal.

Quality standards are a reference point against which projects are evaluated, to; assure staff that programme management decisions are in keeping with best practices; demonstrate that efforts are made to mitigate harm to beneficiaries; and to deliver outcomes in line with Sightsavers' vision and mission.

Meeting a quality standard means meeting the minimum level that all Sightsavers projects are expected to reach. Sightsavers quality standards are reviewed periodically to ensure they are both relevant and consistent with sector developments. Two types of standard exist; Thematic areas and Programme Cycle Management (PCM). **Quality Standards Assessment Tools (QSATs)** are part of routine project monitoring. They are complete or are scheduled in all GiveWell supported countries.

In Guinea for example, a thematic QSAT, conducted in December 2017, contains requirements grouped under the subheadings of; service delivery; health workforce; and programme effectiveness. Each of these requirements can be; not applicable; not met; partially met; mostly met; or fully met, subject to a score derived through the set means of verification (MoV). MoV's include a mix of published documentation, such as drug stock ledgers or NTD master plans, and interviews with key stakeholders.

The QSAT process helps the evaluator allocate each category a score based on the information given and allows the user to see which areas require improvement. Recommendations are made, agreed upon by all stakeholders and actioned in the next round of MDA. Although a cross-organisational tool, the NTD M&E team are also key to conducting the thematic QSATs on NTD programmes and ensuring their recommendations are headed in project design.

The Programme Portal is web based central database, which helps to make project management, reporting and the tracking of project progress easier and more accessible for all Sightsavers staff. It holds information about Sightsavers' projects and programmes, including output data, project documentation, reports and case studies. The Portal is managed by PSMT. Output statistics are submitted either on a yearly or quarterly basis, by country based NTD managers.

All of our M&E functions aim to improve our service delivery; be it defining the areas requiring intervention; measuring our progress against meaningful milestones; or highlighting areas requiring additional efforts.

Direct treatments costs / value for money

Our approach on value for money is broadly based on the four E's:

1. Economy:

Unit cost monitoring – de-worming principally involves school as well as community based work, and sometimes it can be difficult to disaggregate all the relevant costs. SCH MDA in particular is

cyclical not annual (dependant on prevalence), so our preference is to track unit costs over several years and not just look at the annual metrics. Key unit costs are as follows:

- Cost per person trained
- Cost per MDA treatment
(For both the above - looking at actual versus budgeted and understanding the reason for variances).
- Setting targets for expenditure variance and understanding where these are not achieved
- Leveraging use of other funding to reduce cost to GiveWell. Where we share locations/jointly plan with the DFID UK Aid Match funded Oncho/LF project we are able to:
 - Hold joint Annual Meetings
 - Establish joint supervision
 - Carry out joint Monitoring and Evaluation activities e.g. integrated TCS

More broadly, the programme leverages donated drugs (In kind drugs). If these had to be sourced and paid for, there would be a massive negative impact on cost efficiency.

The need for contribution from governments is a constant and is necessary. Our staff and partners work with government funded workers on the programme (whether teachers or health workers) in each country. We are not able to measure the financial contribution this gives to our projects, as there are huge variances across countries/regions of salaries, scope and scale of involvement of government staff.

Examples of economy from the field:

In DRC, the implementing region is on the border with Uganda and hard to access from Kinshasa. There has recently been discussion with the MoH to produce CDD/teacher registers in Arua in Uganda so as to drive down costs relating to production and transportation. This has been agreed in principle, and the unit cost for registers is likely to be reduced from \$5 to \$3 dollars for the next round of MDA.

In addition, in DRC, UFAR use standardised per diem costs and number of days for training, agreed with all NTD partners. The Technical Assistants go to the implementing districts to monitor critical activities, such as training sessions and MDA, data validation, etc. These visits also include activities such as finance checks.

In Guinea Bissau, our consultant for the impact assessment had a three-month contract due to start in mid-September 2017. Due to the delays in conducting the SCH and STH mapping, we divided the consultancy contract into two phases. The first ran up to mid October 2017 and included involvement with the protocol design, with the second part commencing December 2017 for the survey implementation.

In areas where NTD programmes are integrated, some activities can be grouped together to increase value for money for all interventions involved. This can be in the printing of IEC materials, community sensitization and, when drugs are available at the same time, MDA training and distribution.

In Guinea, the integration of NTD MDA activities over the entire country considerably reduced the cost in terms of training, sensitisation and supervision, showing increased value for money. Sensitization efforts included, but were not limited to, a launch ceremony of the MDA activity at district level; radio spots; round table discussions; town criers and mobile sound systems.

In Nigeria, Benue State, the MoH secured an office space for Sightsavers staff based in the state offices, significantly reducing the cost of renting.

2. Efficiency

As above, joint activities with other funded projects mean that time is saved and a streamlined approach is adopted. MDA is conducted in accordance with the National NTD Control Master Plan, which takes into account multiple health interventions.

One key input to efficiency, in terms of delivery to timetable, is for government funded staff to be released at the right time, in line with the MDA timetable.

Examples of efficiency from the field:

In Cameroon, the approved protocol for the Sightsavers impact survey will be used for the other SCH and STH assessments planned for the other regions, with funding from other NGOs. Being able to use the same protocol nationwide was instigated at the design phase and consultation with other NGOs was an important part of protocol development.

In Kwara State, Nigeria, there was collaboration with the Nigeria Leprosy Mission (NLM) in holding joint meetings at the state and LGA level. This was efficient as the NLM provided the transport allowances of its personnel and promoted joint monitoring of programme activities, not duplicating efforts/funding.

3. Effectiveness

This focuses on the quality of interventions and for MDA, measured with the M&E tools and processes mentioned previously. Control and elimination are enhanced by complementary activities such as treatment of adults and BCC (Behaviour Change Communication)/WASH (Water, Sanitation and Hygiene) interventions. The more effective our interventions, the quicker we should achieve the desired impacts of controlling/eliminating SCH and STH across implementing areas.

4. Equity

Principles of social inclusion have taken into account in project planning and are expanded upon in the 'equity, gender and social inclusion' section of the report below. Programmes have better value for money if they are reaching beneficiaries in an equitable manner.

5. Multiplier effects

In addition to the four E's, it's important to take into account the ways in which GiveWell's funding has led to further investment (either financial or in-kind) in SCH and STH programming.

GiveWell's recommendation has made our deworming work more credible to new donors and as such, we have been able to target funding for deworming in a number of integrated proposals currently under review.

Country-specific examples of multiplier effects from the project include the Ministry of Health in Guinea Bissau having officially written to World Food Programme asking for financial support for feeding programmes during SCH/STH MDAs in the targeted regions. In Nigeria, UNICEF is supporting sanitation and WASH activities in Benue State and the GiveWell deworming programme

is collaborating with the organization for WASH activities. This collaboration will further enhance the WASH components of the deworming activities within in the state.

Sustainability

To reach sustainability the project will:

- Promote project ownership by ensuring that MoH, District Local Governments and communities take responsibility for planning, implementing, monitoring and evaluating activities.
- Ensure that services are delivered in efficient and cost effective ways.
- Integrate project activities within the NTD national programme coordination and the routine running of the health services at district and community levels.
- Work with MOH and District Local Governments to ensure that project activities are included in their routine plans and budgets.

These outcomes should ensure that health benefits continue beyond the lifespan of the project.

Examples of sustainability from the field:

In Guinea Bissau, the national NTD team benefitted from working with leading consultants in the areas of mapping and impact assessment surveys for SCH/STH and oncho/LF. The process of creating the protocols and implementing the surveys will be vital in the development of similar surveys in years to come. This is particularly important as the previous SCH/STH impact survey was in 2005 and, as the national NTD team is a relatively new fixture, they did not have prior experience of the activities.

The GiveWell SBCC project in Cameroon is in itself a sustainability project; aimed at improving on the personal hygiene and well-being of school-aged children and their communities. This project is complementing school based MDA with behavioural change communities activities to ensure lasting impact in reducing the prevalence of SCH/STH from all endemic communities. Once the results of the impact survey are available, health districts with high prevalence can be targeted for SBCC interventions, which will ensure sustainability of WASH practices and provide continued health benefits to the entire community.

Equity, gender and social inclusion

Sightsavers launched its social inclusion strategic framework in June 2015. Through this framework, Sightsavers:

- Focuses on mainstreaming disability inclusion within our existing portfolio and operations;
- Develops demonstrable models of effective inclusive education;
- Scales up efforts to achieve diversity in the workplace.

Sightsavers follows a rights based approach as set out in the UN Convention on the Rights of Persons with Disabilities (UNCRPD) to help ensure that interventions are accessible to people with disabilities. Sightsavers and the MOH build on their experience in working with the Federation of Persons with Disabilities in the existing trachoma project whilst exploring opportunities in Guinea Bissau of working with other organisations active in the disability sector such as AIFO and

HANDICAP International. We adhere to three key principles, participation, non-discrimination and comprehensive access.

Sightsavers promotes inclusion alongside NTD elimination activities. People are reached irrespective of their gender, ethnicity, sexual orientation, disability or socio economic status. This is achieved by working in collaboration with Disabled Persons Organization (DPO), relevant government departments and Community Based Organizations (CBOs) that promote women's participation.

As part of our cross cutting issue plans, all countries measure indicators that highlight social inclusion within the programme. These include:

- number of NTD indicators disaggregated by gender
- percentage of persons with disabilities as active community volunteers
- if inclusive survey tools are in place (e.g. equity questions in TCS)

We will first measure the baseline for these indicators and then track progress on a quarterly basis.

Examples of equity, gender and social inclusion from the field:

In Nigeria, efforts to reach marginalised communities, for example training of church members as CDDs helped mobilize the Christian community and has increased awareness amongst Christians, who are a minority group in some of the implementing states.

The Nigerian NTD programmes involve female volunteers from other health interventions in MDA activities, e.g. traditional birth attendants. During community sensitization, the involvement of female volunteers is encouraged. This has resulted in an increase in female CDDs trained in Sokoto and Kebbi. Religious women groups are involved in MDA activities and in turn encourage more women to participate.

To help ensure effectiveness of MDA in school based treatments State level advocacy and sensitization workshops were held for the Ministry of Education (MoE), Primary School Education Board, traditional and religious leaders, the media and other stakeholders.

In Guinea, moving into the next round of treatments, it has been ensured that women have been trained among the national supervisors and women will be encouraged to become CDDs and further mobilize women and girls within the community to participate in MDA activities.

In Guinea, the inception workshop was conducted in such a way that it was able to bring all key partners together such as MoH, Ministry of Education (MoE) and NGOs to participate and share ideas. This resulted in strong commitment for the implementation of the MDA activity.

A similar approach was also taken in DRC with project planning meetings allowing for beneficiary participation. Attendees included stakeholders such as the front-line health facility personnel, community leaders and Health Development Committees. The planning meetings acted as an opportunity to allow active participation in decisions such as scheduling, official launch dates and which treatments/diseases to tackle. Community meetings and sensitization sessions were subsequently held, offering an opportunity for the beneficiaries to nominate CDDs and decide on the dates for training, MDA launch ceremonies and other associated activities.

Risk and mitigation

Sightsavers uses risk matrices to identify and rate programmatic risks and triggers. Each risk accrues a pre-mitigation risk rating based on likelihood and impact

DRC

Insecurity in DRC is growing as is fully reflected in the ever-increasing numbers of internally displaced peoples and refugees. Government's failure to hold timely national elections is exacerbating an already turbulent environment. It would not be surprising for violence to disrupt our work over the coming months. Sightsavers remains committed to working to strengthen our presence in DRC over the coming months and years.

Cameroon

Security issues in anglophone regions of Cameroon flared up at the end of September 2017, culminating in the government calling a state of emergency in October due to violent clashes and bombings.

As of March 2018, there have been sporadic confrontations between the military and the separatists in some villages of South-West and North-West regions that led to some deaths amongst the agitators. Movements in and out of these areas are strictly controlled by the military and Sightsavers has until further notice forbidden the movement of its staff in insecure areas of the two regions.

Data collection for the impact survey has been completed in the West region and is almost complete in the North-West region. Local trainees have been undertaking the work, supervised on the ground by the national NTD team and remotely by Sightsavers staff. The impact survey is currently ongoing in secure areas of the South-West region and there are ongoing discussions with the national SCH/STH coordinator on how to approach data collection in the medium and high-risk areas. The survey design requires samples from these areas in order to build a detailed picture of infection prevalence, irrelevant of security status.

Benue, Nigeria

Conflict between armed groups of herdsmen and farmers over grazing rights also disrupted MDA activities in a number of LGAs within Benue, Nigeria. The insecurity in these areas led to a number of schools delaying the start of term until the conflict had subsided, thus delaying school-based MDA. Some LGAs in Benue are still affected by insecurity and where schools did not reopen a community approach had to be taken, but MDA was able to be completed in one way or another in most areas.

Following MDA, the insecurity also led to some issues with data being collated and verified. Some estimates have had to be used in areas where original treatment documents are either not available, or it is not safe for Sightsavers staff to retrieve them. These estimates will be updated to actuals when it is safe for Sightsavers staff to travel to all affected LGAs.

Supply chain issues

A common issue across the programme has been the availability of required drugs in line with the planned MDA activities. Drugs can be delayed for a number of reasons, including late orders, international shipping delays, import bureaucracy and internal delivery issues. Although these are

ultimately the responsibility of the governments involved, partners such as Sightsavers can influence certain aspects of the process to help mitigate negative effects of delays.

In Nigeria, for example, where drugs were stuck at the port, the Sightsavers Country Director kept pressure on the authorities on a daily basis to advocate for a timely solution to the problem. In the meantime, the team were able to tap in to a nationally coordinated effort to re-distribute praziquantal from states where it was no longer needed to make a start on MDA in states where it was required.

Summary of lessons learnt

Our programme learning is derived from our experience with both oncho/LF and SCH/STH MDA in the GiveWell funded countries. Learning is captured in our monthly status reports, but has been summarised below according to the six pillars of the health system:

Health Workforce

The health workforce includes people at a number of levels, from CDDs within their communities, to local and regional health workers, up to senior members of the MoH. Attrition of CDDs is a problem we have learned about through years of working with the community directed approach and motivation is key if they are to continue working for the programme year on year. In interviews,¹⁰ we have found that most CDDs state their main motivation as keeping their communities free from disease. In the rural communities, it is also noted that they consider it better to prevent the disease than to try to cure it, as many of them do not have the money/access to medical facilities to receive treatment. Free distribution of preventative drugs is therefore their preferred option.

In previous years working with the oncho/LF programme in Guinea Bissau, it was found that not all CDDs who were trained went on to complete the MDA. Anecdotal evidence from the MoH and regional health workers tells us that part of the problem was that the data collection process was considered too time consuming and complicated. In reply to this, the most recent round of MDA used new tally-style data forms to replace the old CDD registers. The new forms do not require the CDD to write a lot of information (such as the beneficiary name) and instead allows them to tick a box for everyone they treat of a certain sex/age/height. All returning CDDs interviewed said they preferred the new style data form and found it more motivating than the old CDD register. The learning from the oncho/LF programme has been taken forward in the inaugural SCH/STH campaign, where the data forms will be adapted for SCH/STH and a school-based campaign.

Supply chain management

Although some issues of supply chain management are beyond partners control, for example the retention of praziquantal in the Nigerian port for bureaucratic reasons, there are areas in which partners can assist. During the praziquantal shortage in Nigeria in 2017, the team were able to start MDA using surplus praziquantal available from previous rounds of MDA in neighbouring states who did not require the drugs in 2017. This enormous effort was coordinated at a national level and Sightsavers utilized the system to make a start on SCH MDA wherever possible.

During a field visit to Sokoto State, Nigeria, it was discovered that a number of communities had not received the required amount of drugs to treat the whole community for Oncho/LF. When discussing the preparatory process for MDA with community leaders and the State MoH, it was

¹⁰ As part of our training and data flow review process 2017-18

discovered that the communities in question had not updated their census forms before the drugs were requested from the state.

We then had the opportunity to explain the link between the accurate census data and the required amount of drugs being allocated to a community. As the Oncho/LF MDA was conducted prior to SCH/STH, this learning could be used immediately for the 2017 round of SCH/STH MDA.

Another way that partners help in supply chain management is by working with the MoH during the drug ordering process to ensure that the JRSM is completed correctly and based on up to date population and infection prevalence data.

Service delivery

A common issue across the programme is the population denominator used to estimate coverage. In Guinea and Nigeria, the denominator was too low, leading to coverage rates exceeding 100%, but in Guinea Bissau the original population estimate was too low and treatment targets had to be changed in line with an updated population estimate from the government. As well as unreliable census data, population estimates for school-based programmes such as SCH/STH MDA are often incorrect due to Ministry of Education school lists being out of date. This has been the case in all countries involved in the GiveWell programme, evidenced by the over-achievement of output 1.4 across the board. Many schools are unregistered with their respective MoE for a number of reasons, including being private or faith-based (primarily Cristian or Islamic). To try to rectify this issue, Sightsavers plans to share the list of schools treated with the respective MoE's to help update their records. We will also use the 2017 achieved figure for output 1.4 as the target figure for 2018 (where the implementation area does not change).

Even when the school list is accurate, we have also learned that there is often a difference between the reported enrolment rate and the actual attendance rate. In some areas where we expected a high enrolment rate, attendance has been low and school-based MDA has therefore needed to be supplemented with community-based MDA. This was the case in Guinea, where the team came up with the strategy to mark a child's hand with a marker pen once they had been treated to avoid duplicate treatments at school and within the community.

Service delivery is also affected by timings of public and religious holidays. In Guinea, MDA had to be organised and completed in a short timescale so that they could treat before Ramadan started; this is important, as praziquantal must be taken with food, so it is not possible to administer the drug during the school day at a time of fasting. The MDA could not be planned for after Ramadan as it would then be the school summer holidays and again school-based MDA could not take place. Similarly, in Nigeria where praziquantal delivery was delayed, the MDA had to take place in the 4 States in the few weeks leading up to the Christmas holidays. In Benue, the drugs were not delivered until during the Christmas break and so training and MDA could only take place in early January once schools had resumed. An added complication in Benue was the fact the not all schools opened as scheduled due to insecurity in the region. This lead to further delays and MDA needing to continue into February 2018.

HMIS (information and research)

In both Guinea Bissau and Cameroon, we have been through the process of developing protocols for SCH/STH impact surveys. In both cases, the protocol development exceeded the allocated timeframe. Survey protocols are complex documents requiring not only scientific rigour, but also buy-in from a number of different stakeholders in order to exceed. Our original plans did not allow enough time for all parties to give comments and agree on the final wording and so both protocols

were delayed. Once the protocols were finished field activities were implemented smoothly; we are therefore satisfied that spending more time on stakeholder buy-in was worth the delay in activities as successful impact surveys in Guinea Bissau and the West region of Cameroon (NW and SW regions ongoing). In future, we will make sure to allocate more time to protocol development in order to complete impact surveys in a timely manner and in line with MDA scheduling.

As part of both the GiveWell and UK Aid Match programme, we have undertaken a piece of work gathering information on training and data flow throughout the projects. Data Flow, in the context of this piece of work, is the movement of MDA data through the reporting system; from when it is initially captured by the CDD on the data sheet, to when it is sent to the Ministry of Health for official reporting purposes. Training, in this context, is both training of individuals to undertake the MDA process and the training of trainers to deliver this information.

From October 2017 to December 2019, each programme country will be visited by a Programme Officer who will undertake a Terms of Reference aimed at collating existing information on training and data flow and making recommendations based on these findings. At the time of reporting, project sites have been visited in Nigeria, Guinea Bissau and DRC. Once collated, this information will underpin a qualitative review of our data flow and training processes, enabling cross-country learning and recommendations for improvements in both areas.

Governance

One of the lessons we have learnt across our programme is the need for a strong national NTD team to cope with transitions and ensure continuity of service. In situations where governments change regularly, it is important to have well trained NTD staff consistently in position within the MoH. In Guinea Bissau, we are working in partnership with a relatively new NTD department, only fully established in 2015. In conjunction with this learning, Sightsavers are investing in capacity building for this team to embed NTDs firmly into the Ministry of Health.

Financing

The withdrawal of USAID funding for deworming MDA in Cameroon has re-enforced the idea of flexible programming. As a complementary strategy in SCH/STH control, our WASH programme would not have the desired impact if it were done without the required MDA. We will therefore have to divert some money towards plugging any gaps in MDA funding in the regions we are working in.

Summary of changes to the project plan

Sightsavers uses the most current scientific evidence at its disposal to plan and deliver its projects. As such, results from impact surveys, such as the one undertaken in Guinea Bissau precipitate necessary changes to the project plan, as laid out in the logical framework.

Project timeline

Across the programme, impact survey and drug delivery overruns required the extension of MDA related activities into Q1 of 2018. Therefore, to better align activities with the money spent on them and more accurately calculate costs per treatment, we have reported all accomplishments with their respective costs from Jan 2017 to 31st March 2018. All future project years will subsequently run April – March.

Guinea Bissau

Due to the results of the survey, the MoH has taken the decision to change the regions requiring MDA for SCH/STH based on the infection prevalence. Rather than a change in strategy, the mapping has allowed us to change the geographic area requiring coverage. Whereas previously we were planning interventions in only eight of the health regions, the lower prevalence and therefore fewer treatments required means that we can now reallocate resources to treat as required on a national scale, rather than leaving some endemic regions unfunded.

Cameroon

The current project in Cameroon focuses on Social Behaviour Change Communication (SBCC) surrounding Water, Sanitation and Hygiene (WASH) as a complementary strategy, working alongside MDA. In three regions of Cameroon, Sightsavers received USAID funding via HKI to support MDA for multiple NTDs. In 2017, we advised GiveWell that in 2018 USAID (via HKI) were reducing their budget allocation and would no longer provide funding for deworming MDA in the project areas and that Sightsavers did not have the unrestricted funds available to fill the new funding gap for this work that this decision created.

Our commitment to Cameroon was 'grant fund permitting'; meaning our ability to deliver this work at the levels seen in recent years was based on securing restricted funding. Given the scale of the activity in question, and other demands on organisational funds, without GiveWell's support it would not be possible for Sightsavers to continue supporting the deworming element of the programme given the reduction of USAID funding.

Cameroon is currently implementing an impact survey for SCH and STH that will allow for the re-evaluation of required treatments based on updated regional infection prevalence. Once it is known which regions require treatment, a treatment strategy will be devised. The Cameroonian Ministry of Basic Education will put money toward the MDAs, but are unlikely to be able to fund the entire campaign.

If a partner is required to support SCH/STH MDA in the West, North West and South West regions, then Sightsavers will allocate some of the GiveWell funding to the campaign. It is currently proposed that the 2018 Q1 quarterly grant would cover these costs. This is necessary, as there is no use in running a complementary WASH project where there is no ongoing MDA to complement.

WASH

Our investigation into existing reporting within respective ministries of education showed that six key WASH indicators were not being routinely measured in any of the areas the project is working in. Our targets for year 1 were based on assumed baselines in each country, but as the baseline is 0% across the board, these targets will need to be addressed. Our work in this area will continue to encourage cross-sectoral coordination and advocate for a complementary strategy approach.

Wishlist 2

Our Wishlist 2 submission in September 2017 emphasised some of the more general changes we have made to strengthen monitoring and evaluation (M&E) throughout the programme; including additional M&E focussed staff and a more systematic use of M&E tools and surveys. Please see the M&E section of this report for further details.

Subsequent changes in logical framework (planning, management and monitoring tool)

Milestone dates

- Changes made to all Cameroon SBCC milestone dates to better reflect project progress (due to delay in impact survey)
- Changes made to all other countries milestone dates to reflect project 'year 1' lasting 15 months (Jan-17-Mar18) and all following project years being April-Mar

Output targets

- In Nigeria, the 2016 JSRM was used to calculate treatment targets. This document is reviewed annually and thus some of the targets have changed slightly due to amendments in the source document
- The Cameroon SBCC output targets have been amended in line with WASH reporting findings across the rest of the GiveWell programme
- At least one TCS is included for each country and/or region, each year

New project areas

Guinea 5 provinces and Nigeria Yobe are now separate tabs to the Logical framework from year 2 onwards to reflect new funding allocations from Wishlist 2.