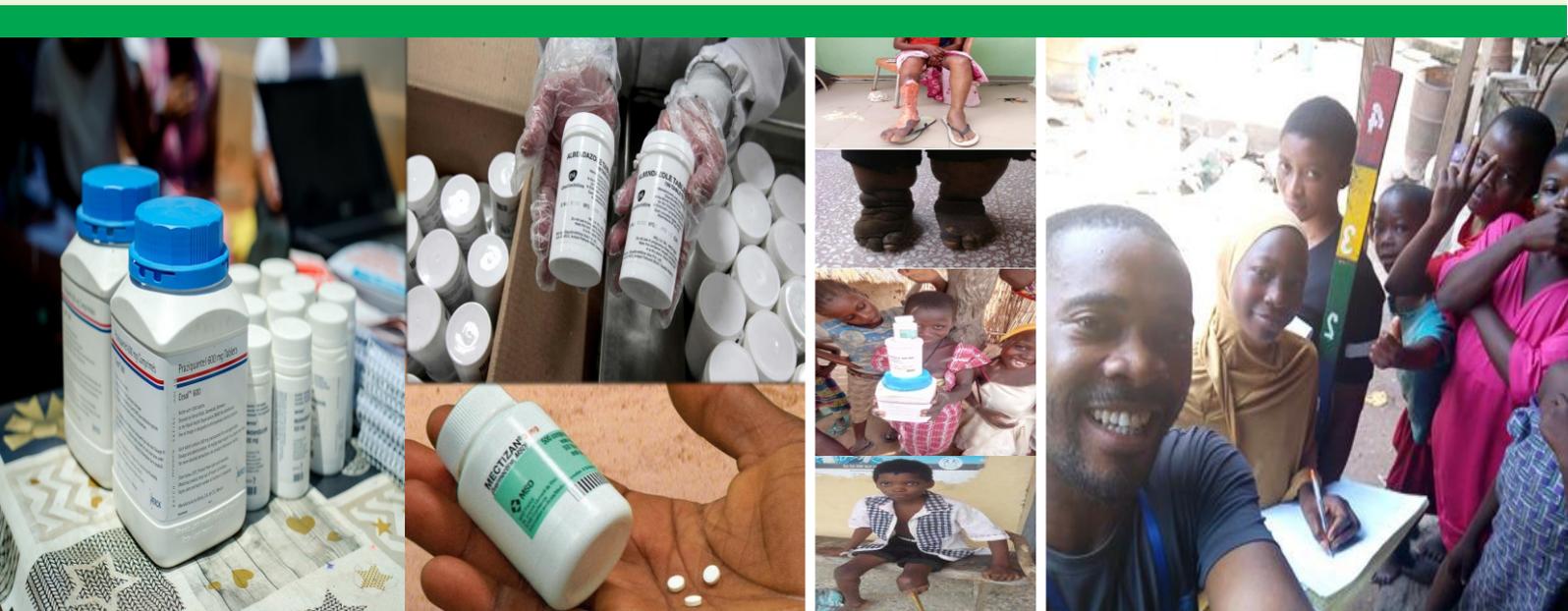




## FEDERAL MINISTRY OF HEALTH



# NIGERIA MASTER PLAN FOR NEGLECTED TROPICAL DISEASES (NTDs)

**2023 - 2027**

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## LIST OF ACRONYMS

|           |  |
|-----------|--|
| ACSM      | Advocacy Communication for Social Mobilization                             |
| ADR       | Adverse Drug Reaction  |
| AIDS      | Acquired Immunodeficiency Syndrome   |
| ALB       | Albendazole  |
| ALM       | American Leprosy Mission   |
| APOC      | Africa Programme of Onchocerciasis   |
| AU-PATTEC | African Union- Pan African Tsetse and Trypanosomiasis Eradication campaign |
| BU        | Buruli Ulcer   |
| CAMH      | Conference of Africa Union Minister of Health                              |
| CATT      | Card Agglutination Test for Trypanosomiasis                                |
| CBM       | Christofel Blind Mission International                                     |
| CBM       | Christofel Blind Mission Global  |
| CDD       | Community Drug Distributor   |
| CM        | Case management  |
| CL        | Cutaneous leishmaniasis  |
| CPSS      | Community Participatory Surveillance Strategy                              |
| CRPD      | Chronic obstructive pulmonary disease                                      |
| CSM       | Cerebrospinal Meningitis   |
| CWW       | Children Without Worms   |
| CWW       | Dried Blood Sports   |
| DCL       | Diffuse Cutaneous Leishmaniasis  |
| DF        | Damien Foundation  |
| BRA       | Dracunculiasis   |
| DHIS2     | District Health Information Software 2                                     |
| DQA       | Data Quality Assessment  |
| ERGP      | Economic Research and Growth Plan  |
| FGC       | Female Genital Schistosomiasis   |
| FMARD     | Federal Ministry of Agriculture and Rural Development                      |
| FMOH      | Federal ministry of Health   |
| FCT       | Federal Capital Territory  |
| GARC      | Global Alliance for Rabies Control   |
| GDP       | Gross Domestic Product   |
| GLRA      | German Leprosy and TB Relief   |
| GNP       | Gross National Product   |
| GSK       | Llaosmithkline   |
| GPW13     | Thirteenth General Programme of Work 2019–2023                             |
| HANDS     | Health and Development Support Programme                                   |
| HAT       | Human African Trypanosomiasis  |
| HIV       | Human Immunodeficiency Virus   |
| HKI       | Helen Keller International   |
| HMIS      | Health Management Information System                                       |
| HPAI      | Highly Pathogenic Avian-Infuenza   |
| IDSR      | Integrated Diseases Surveillance and Research                              |
| IDP       | Internally Displaced Person  |
| IDM       | Innovative (Intensified) Disease Management                                |
| IEC       | Information, Education and Communication                                   |

|          |   |
|----------|---|
| IRS      | Indoor residual spraying  |
| ITN      | Insecticide-treated net   |
| IVM      | Integrated vector management  |
| IU       | Implementation Unit   |
| JRSM     | Journal of the Royal society of Medicine                            |
| LCL      | Local Cutaneous Leishmaniasis                                       |
| LEISH    | Leishmaniasis   |
| LMIS     | Logistic Management Information System                              |
| LF       | Lymphatic filariasis  |
| MCL      | Mucocutaneous Leishmaniasis   |
| MDA      | Mass drug administration  |
| MDP      | Mectizan Donation Program   |
| MDT      | Multi-Drug Therapy  |
| MEB      | Medical Evaluation Board  |
| MAM      | Mass Administration of Medicine                                     |
| MITOSATH | Mission to Save the Helpless  |
| MMDP     | Morbidity management and disability prevention                      |
| NAFDAC   | National Agency for Food and Drug Administration and Control        |
| NEMA     | National Emergency Management Agency                                |
| NESREA   | National Environmental Standards and Regulations Enforcement Agency |
| NHA      | National Healthcare Association                                     |
| NHMIS    | National Health Information System                                  |
| NSHDP    | National lymphatic Filariasis Elimination Programme                 |
| NLR      | No Leprosy Remains  |
| NPHCDA   | National Primary Health Care Development Agency                     |
| NSHP     | National Strategic Health Development Plan                          |
| NSP      | Nigeria Society of Physiotherapy                                    |
| NTBLCP   | National Tuberculosis, Leprosy & Buruli Ulcer Control programme     |
| NTD      | Neglected tropical diseases   |
| NJGO     | National Non-Governmental Development Organizations                 |
| NGO      | Non-governmental organization                                       |
| NOEC     | National Onchocerciasis Elimination Committee                       |
| OEM      | Onchocerciasis Elimination Mapping                                  |
| OH       | One Health  |
| OIE      | Office International des Epizooties                                 |
| ONCHO    | Onchocerciasis  |
| PC       | Preventive chemotherapy   |
| PCR      | Polymerase Chain Reaction   |
| PESTA    | Political, Economic, Social and Technological Analysis              |
| PHC      | Primary Health Care   |
| PWDs     | PWDs Person With Disabilities                                       |
| RTI      | Research Triangle International                                     |
| RUWASA   | Rural Water Supply and Sanitation Agency                            |
| SAEs     | Severe Adverse Events   |
| SAR      | Severe Adverse Reaction   |
| SARI     | Severe Acute Respiratory Infection                                  |
| SBCC     | Social and Behaviour Change Communication                           |
| SHC      | Schistosomiasis   |

|         |  |
|---------|--|
| SDGs    | Sustainable Development Goals  |
| SIS     | Statistical Information System   |
| ATH     | Soil-transmitted helminthiasis   |
| SOP     | Standard Operating Procedure   |
| SWOT    | Strengths, weaknesses, opportunities, and threats Transmission Assessment Survey |
| TAS     | Traditional Birth Attendants   |
| TCC     | The Carter Center  |
| TIPAC   | Tool for Integrated Planning and Costing   |
| TLMN    | The Leprosy Mission Nigeria  |
| TOR     | Terms of Reference   |
| TRA     | Trachoma   |
| UN      | United Nation  |
| UNICF   | United Nations Children's Fund   |
| UHC     | Universal Health Coverage  |
| UNGAIDL | United Nation General Assembly   |
| VHF     | Viral Hemorrhagic Fever  |
| VL      | Viral load   |
| WAR     | World Health Assembly resolution   |
| WASH    | Water, sanitation and hygiene  |
| WHO     | World Health Organization  |

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## EXECUTIVE SUMMARY

Neglected Tropical Diseases (NTDs) are associated with poverty and are prevalent in areas that have poor sanitation, inadequate or no safe water sources and substandard housing conditions. Persons who are affected experience intense poverty as they impose devastating physical, social and economic challenges.

To achieve the Sustainable Development Goals (SDGs), it is important to end the neglect of these diseases. In Nigeria, it is estimated that over 122 million persons are at risk of one or more of these NTDs (NTD master plan 2015-2020).

Nigeria spanned about 923,768sq km and is bounded by three countries: Cameroon in the east, Benin in the west and in the north by Niger. On the North-eastern region, it is bounded by the Chad and Niger republic. As the most populous country in Africa, challenges such as underdevelopment, large burden of socioeconomic challenges and diseases are common. The country is made up of 6 geo-political zones comprising 36 States, a Federal Capital Territory (Abuja), and 774 Local Government Areas (LGAs).

Universal Health Coverage (UHC) is the goal of the country's health system which is achieved primarily through its Primary Health Care (PHC) system and other levels of care such as secondary and tertiary levels. The NTD programme is majorly implemented through the PHC system that reaches the nooks and crannies of communities where interventions are needed the most.

The situational analysis focuses on 13 of the 20 global NTDs, namely: Lymphatic filariasis, Onchocerciasis, Schistosomiasis, Soil Transmitted Helminthiasis (STH), Trachoma, Human African Trypanosomiasis (HAT), Dracunculiasis (Guineaworm Disease), Leprosy, Buruli Ulcer, Rabies, Leishmaniasis, Yaws, and Snakebite Envenoming. The prevalence of these diseases is somewhat known because of the established structure in the ministries of health at the state and federal levels. However, the strategic plan indicates plans to confirm the presence or absence of other NTDs. Moreover, the plan includes analysis of programmes that are closely related to the NTD program, such as vector control, One Health, WASH, pharmacovigilance, mental health, and disability inclusion.

The goal of the NTD programme is to progressively reduce morbidity, disability, and mortality due to NTDs using integrated and cost-effective approaches with the view to eliminating NTDs in Nigeria by the year 2030.

The operational framework component of this NTD master plan describes how Nigeria will in practice implement the planned activities. It explains what the country's capacity needs are, how resources will be mobilized, how potential risks will be addressed, the scale-up strategy, verification, and assessment of disease elimination and how the sustainability of the project achievements will be ensured. Mass drug administration, case management and cross cutting approaches are the main strategies that will be used to achieve the stated goals and objectives in the control of NTDs in Nigeria.

The strategic plan has 4 strategic pillars, 29 priority areas and 147 activities, it is expected that a total of eight billion six hundred and forty one million, five hundred and fifteen thousand and three hundred and sixty three naira is required to fund the five-year plan. The tool will be used as a resource mobilization tool to bridge the existing funding gaps.

## FOREWORD

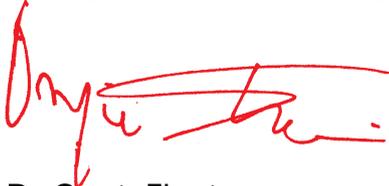
The goal of controlling, eliminating, and eventually eradicating neglected tropical diseases (NTD) has gained considerable momentum in recent years. The WHO Strategic and Technical Advisory Group on Neglected Tropical Diseases and its partners adopted a road map for 2012-2020, intensifying their efforts to reduce the burden of neglected tropical diseases. The development of the NTD Master Plan for 2012–2017 and a modified plan for 2015–2020 marked a turning point in Nigeria's fight against neglected tropical diseases, during which implementation of the plan and performance evaluation were also carried out.

2. The findings have showed considerable improvements for public health, such as the expansion of control and elimination programmes and improved access to medicines, which have helped hundreds of millions of poor and marginalised communities through an innovative and cost-effective partnership. However, there are still gaps in community awareness, ownership, resource mobilisation and support for NTD case management.

3. Given the nature of NTDs, their eradication needs strong collaboration with other key sectors and the building of a strong, resilient, and robust health service delivery system that is accessible to all, including marginalized and disadvantage populations.

4. The Nigeria NTD master plan 2023-2027 contains four strategic priorities in support of WHO's strategy to accomplish the last mile of NTD services, as outlined in the WHO Road Map for 2021-2030. These include accelerating programmatic actions, intensifying cross-cutting approaches, operating models, a culture to facilitate country ownership, and strengthening resource mobilisation and cross-sectoral engagement for NTD eradication. In addition, four (4) essential elements are highlighted: NTD situation analysis, Strategic Agenda, NTD operational framework, and impact budgeting. As well as programme goals, objectives, and a five-year strategy based on a thorough scenario analysis.

5. I urge NTD programme administrators, partners, donors, students, and stakeholders to use this document as a useful resource mobilization tool. It will also assist NTD programme managers with preparation and implementation of annual plans for the next five years, as well as the constant monitoring of progress toward specified goals and target.



Dr. Osagie Ehanire  
The Honourable Minister  
January 2023.

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Finally, I wish to appreciate the National Coordinator, NTDs, and his formidable team, for their hardwork, dedication, and commitment.



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## INTRODUCTION

The Neglected Tropical Diseases (NTDs) Programme Master plans are essential components for effective planning and implementation of sustainable NTD programmes. The Plan provides programme goals and objectives, as well as a five - year detailed strategic plan based on extensive situation analyses and addresses all components of the NTD programmes considered relevant to Nigeria. It provides the basis for integrated or linked NTD project plans and includes costing and financing requirements for effective NTD programme implementation and performance.

The national NTD Master Plan forms the basis for harmonized implementation and performance monitoring of all NTD interventions in the country. The Plan aims to provide all partners and stakeholders working on NTDs in Nigeria with a harmonized tool that will facilitate integration, partnership and collaboration and therefore effectively manage available resources while reducing wastage. The Plan will also facilitate the achievement of the 2030 NTDs elimination targets and goals as defined in WHO Road Map 2021-2030 Regional Committee Resolution. It is guided by the BEST Framework and is emphasized in this revised version of the Plan and adequately described and covered in the Plan. These are as follows:

- B- Behavioural
- E- Environment
- S- Social Inclusion
- T- Treatment

The following will be brought into perspective in the implementation of this Master Plan:

- Reflection of lessons learnt and how they affect the new approach
- Strategies are comprehensive, and linked to national priorities, targets and goals to cover all NTDs; preventive chemotherapy and case-management NTDs
- Planning based on national strategic priorities rather than a disease or an initiative is fostered.
- Activities with other health interventions and within the NTD programme to solve shared problems integrated and consolidated.
- Costs financing of the NTD Programme in order to ensure financial sustainability, and links the NTD programme to health sector planning and financing mechanisms.
- The Master Plan provides a strong base for the country's annual NTD work plans.
- Implementation of the Plan promotes partnership and collaboration.

Progress in implementation of planned activities as well as the programme performance and output will be monitored regularly and evaluated at appropriate intervals. The strategic plan will be the framework for partner coordination, harmonization, and alignment. The content is expected to enhance commitment and accountability, transparency, evidence based and verifiable plans of all stakeholders to enhance effective and sustainable resource mobilization.

Stakeholders will regularly review progress and lessons learnt from previously implemented and ongoing activities, based on which the national Plan may be reviewed and updated as required in order to meet the 2030 goals. Impact assessments where needed may be conducted during the course of events

The preparation of the original Master Plan comprised the following steps which included desk reviews

and consultations with the National NTDs Steering Committee, partners, and stakeholders in the country, as well as consideration of outcomes of various monitoring and evaluation activities.

This Master plan comprises four major components:

- NTD Situation analysis.
- The NTD strategic agenda: Purpose and Goal
- The NTD Operational Framework.
- Budgeting for Impact: Estimates and Justification

The situation analysis covers the NTDs, the health system, and the external profile. The NTD's strategic agenda covers the mission, vision, strategic milestones, and priorities. The operational framework covers strategic initiatives and activities towards programme sustainability while addressing risk and mitigation. The States will domesticate this plan.

## • PART ONE: SITUATION ANALYSIS •

### Section 1.1. Re-assess National Priorities and the national, regional, and global NTD Commitments

This Master Plan is an update of the previous NTDs Master Plan (2015–2020). The development of the previous master plan was guided by global priorities informed by various reforms, including the Ouagadougou Declaration on Primary Health Care (WHO, 2008) I with emphasis on Primary Health Care within the context of health systems strengthening; the World Health Assembly Resolution 58:33 (WHO, 2005)<sup>2</sup> on increasing access to needed services; and the World Health Assembly resolution WHA 66.12 (3) passed in 2013 to control, eliminate, and eradicate NTDs by 2020. The NTDs gained prominent priority, as evidenced by their inclusion in the United Nations Agenda for Sustainable Development Goal 3 (SDG3), wherein it was stated that "by 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases" (UN, 2015). Based on learnings from the past implementation of NTD interventions, the current WHO Roadmap for NTDs 2021–2030 urges countries to prioritise integrated approaches for the control, elimination, and eradication of NTDs by 2030 (WHO, 2020).

Since Africa contributes to at least 40% of the global NTD burden, there is growing interest in NTDs, and regional policymakers have included NTDs on the list of regional priorities (WHO, 2018).<sup>7</sup> In 2013, the 6th session of the Conference of African Union Ministers of Health (CAMH6), convened with the theme "Impact of Non-Communicable Diseases and NTDs on Africa's Development," endorsed a continental framework for NTD control and elimination (African Union, 2013). Furthermore, the recently launched Kigali Declaration on NTDs (Uniting to Combat Neglected Tropical Diseases, 2022) seeks to mobilise political will and secure commitments to end NTDs in the African Region, aligned with the WHO Roadmap for Neglected Tropical Diseases (2021–2030),

NTDs are included in priority area five of Nigeria's Second National Strategic Health Development Plan (2018–2022), with the goal of "improving prevention, case detection, and coordinated response for the management of communicable diseases and NTDs" (FMoH Nigeria, 2018–2022).<sup>12</sup> Also, the Nigeria National Health Policy 2016 lists four strategies for NTD control and elimination (FMoH Nigeria, 2016).<sup>13</sup> The National NTD Program currently addresses lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminths, trachoma, leprosy, buruli ulcer, human African trypanosomiasis, snakebite envenoming, rabies, yaws, and leishmaniasis. Since 2013, Guinea worm disease has been eradicated in Nigeria. The other eight diseases that are considered NTDs globally have not yet been mapped to ascertain if they are endemic in Nigeria.

The Nigeria NTD master plan 2023–2027 focuses on four major parts: NTD situation analysis, strategic agenda, NTD operational framework, and budgeting for impact. It also contains programme goals, objectives, and a 5-year strategy to progressively reduce morbidity, disability, and mortality due to NTDs using integrated and cost-effective approaches with a view to eliminating NTDs in Nigeria by the year 2030.

Considering the nature of NTDs, the goal of their elimination is built around collaboration with other relevant sectors as well as building a strong, resilient, and robust health service delivery system that is accessible to all, including the marginalised and disadvantaged segments of the population.

## National Context Analysis

### Political:

Nigeria is made up of six geo-political zones comprising 36 states, a federal capital territory (Abuja), and 774 local government areas (LGAs). The country operates a federal system of government with an elected president at its head. Other arms of the government are the executive, judiciary, and legislative (the Senate and House of Representatives).

Even though the federal government, the National Assembly, and the state governors have real political power and access to state funds, the heads of state of African Union countries agreed in 2001 that at least 15% of the annual budget should be used to improve the health sector. This goal has not been met.

Likewise, most regions of Nigeria are now affected by conflict and violence, leading to the displacement of nearly 15 million people across the northeast. This has hampered the achievement of critical programme goals, such as the completion of trachoma mapping in Borno State's ten local government areas, the implementation of mass administration of medicine, and the conduct of impact assessments.

Through its agencies and ministries, the federal government controls who can get an import duty exemption certificate (IDEC). Government bureaucracy often slows down the arrival and availability of NTD medicines. Political commitment at all levels is needed, as is making sure that institutional arrangements support NTD interventions.

Having a master plan that aligns with the term of a new government and integrating its implementation into the government system is key to the sustainability of the program.

### Economy:

In 2021, foreign aid for NTDs, such as the Accelerate the Sustainable Control and Elimination of Neglected Tropical Diseases (ASCEND) programme, was reduced since the COVID-19 epidemic harmed the economies of most nations. This affected twenty-three African nations, including Nigeria.

Despite Nigeria's GDP expanding by 1.8% in 2020 and expanding by 3.6% in the same period of 2021, macroeconomic stability deteriorated. Due to global commodities shocks, a weakening currency, trade restrictions, and an increase in the cost of goods and services, inflation is skyrocketing and plunging millions more Nigerians into poverty.

Since NTDs are widespread in extreme poverty, this can exacerbate the burden of NTDs in Nigeria. To end the suffering caused by NTDs, it is necessary to improve Nigeria's economic outlook and enhance its domestic financing capacity.

### Social:

NTDs have a significant social impact, leading to stigma and discrimination, and can be affected by social factors such as migration, high rates of poverty, and traditional and religious beliefs. Analysis of the social factors that determine the causation, impacts, and interventions of NTDs is critical. such as Health-Seeking behaviour, illiteracy, and cultural beliefs that impede beneficiaries from accepting intervention services are critical. The purdah system practised in the north affects the geographic and therapeutic coverage of programme implementation. Poor health systems and infrastructure, poor access to health care facilities, inflated costs of services and goods for beneficiaries, post-donor support, stigmatization, and discrimination are all important factors to address in the campaign against NTD.

Poor waste disposal and drainage systems result in flooding, making communities hard to reach during NTD implementation. Poor personal hygiene (face and body) at the community level, inadequate

hygiene promotion activities in communities and schools, and the increasing demand for incentives from the community drug distributors all could form a barrier to the elimination goal of NTD.

### **Technology**

With more people having access to cell phones, computers, and the internet, digital technology has become an important tool in the fight against neglected tropical diseases. This is because it makes it easier to digitise NTD campaigns such as microplanning, training, supply chain management, monitoring and evaluating, and raising awareness.

Over the last two years, efforts have been made to transition NTD treatment reporting from paper to DHIS. Mobile platforms like ESPEN Collect are used to collect data during coverage evaluation surveys and impact assessments. This gives people access to timely and high-quality data, and TT Tracker has improved the delivery of services and management of trachoma surgeries.

The Nigeria NTD programme will explore additional technologies, such as Viamo, an interactive voice messaging system, to reach out to hard-to-reach populations with training and NTD campaigns at a low cost, as well as VTR Mobile to increase healthcare workers' capacity on the diagnosis and treatment of skin NTDs..

### **Health System Analysis**

Nigeria practises an orthodox and traditional approach and system in the delivery of health care. Both systems operate side by side, but with limited collaboration and integration. Orthodox health care services are provided by both the private and public sectors. The public health service has three levels: the primary, secondary, and tertiary levels. The lines between the roles and responsibilities of the three levels are intertwined and, in some cases, blurred. However, the Health Bill assigned or stated the responsibilities of each of the levels.

The FMOH estimated 39,402 health facilities in Nigeria in 2019, with 28,952 (73.5%) being public and 10,450 (26.5%) being private. Of this total, 27,629 (70.1%) are primary health care facilities, 1,225 (2.7%) are secondary, and 98 (0.2%) are tertiary. The private sector owns 38% of these facilities, and they provide 60% of the health care in the country. Recent data indicates an increase in the number of health facilities to over 35,000 (Nigerian HFR, 2019). The federally owned tertiary facilities provide specialist services that are mostly not available at the secondary and primary levels, with the teaching hospitals also providing training for health workers and research.

The Primary Health Care (PHC) system is the bedrock of the national health system, and the majority of NTDs can be managed at this level. To achieve the sector's goal, interventions should be integrated and delivered through a unified platform. This will require political will, funding capacity, a skilled workforce, and availability of essential drugs to deliver quality service.

**Table 1: Six Health System Building Blocks**

|                         |   |
|-------------------------|---|
| <p>Service delivery</p> | <p>The Nigerian health service delivery system is based on primary health care and includes among other things:</p> <p>Education concerning prevailing health problems and the methods of preventing and controlling them</p> <ul style="list-style-type: none"> <li>• Promotion of food supply and proper nutrition</li> <li>• Maternal and childcare, including family planning</li> <li>• Immunization against the major infectious diseases</li> <li>• Prevention and control of locally endemic and epidemic diseases</li> <li>• Provision of essential drugs and supplies.</li> </ul> <p>There is a three-tier system of health care namely: Primary Health Care, Secondary Health Care, and Tertiary Health Care. Common NTD interventions include preventive chemotherapy through mass administration of medicine using both community and school-based approaches. Others include vector control, morbidity management and disability inclusion, and promotion of mental wellbeing. However, achieving effective coverage of PC NTD intervention in urban area still remain challenging due to poor awareness and visibility of NTDs.</p>  |
| <p>Health workforce</p> | <p>According to the 2018 Nigeria Health Workforce Country Profile, Nigeria has 74,543 physicians and 124,561 registered nurses and midwives. Despite an increase in the number of women entering the health professions in Nigeria, they are grossly underrepresented in leadership and decision-making roles. Many of the highest HRH leadership and managerial posts at the federal and state levels are held by men, showing gender inequality in terms of career advancement and attainment of positions with decision-making authority.</p> <p>In Nigeria, persons with disabilities (PWD), who account for nearly 25 million people or around 13 percent of the population, are routinely barred from the training and recruitment of certain categories of health workers, including nursing and midwifery personnel. Although the Discrimination Against Persons with Disabilities Prohibition Act of 2018 has been established to protect PWDs, negative perceptions of PWDs and their abilities continue to impede their access to pre-service training and entry into the health workforce. Nigeria has attempted to address the country's health workforce challenges through a number of policy initiatives, including the "National Health Act (2014)", the "National Health Policy (2016)", the "National Human Resources for Health Strategic Plan (2008-2012)", and the "National Strategic Health Development Plan (NSHDP) II (2018-2022)".</p> <p>Other nonconventional health workforce includes mostly volunteer community drug distributors and schoolteachers trained to deliver medication during NTD campaigns. However, they constitute the largest proportion of workforces engaged in NTD intervention.</p> |

|                                  |   |
|----------------------------------|---|
| <p><b>Health information</b></p> | <p>The Health Management Information System (HMIS) of the Department of Health Planning collects, collates, analyses, and interprets routine data from the nation's health facilities. There is a national strategy on HMIS whose objective is to develop the National Health System so that it can offer effective, efficient, quality, accessible, and affordable health services that will improve the health condition of Nigerians by achieving health related MDGs. Health information from health facilities is collected using HMIS tools and transferred from Local Government Areas to the Planning Department of the FMOH via the State Ministries of Health. The findings serve as the basis for health intervention policy creation, evaluation, and strategic planning. Already, the majority of NTDs in Nigeria are captured in the HMIS, but these are facility-level data. The HMIS forms need to be updated to incorporate all NTDs.</p> <p>Another important source of health information is the Integrated Disease Surveillance and Response System (IDSR), which contains forty priority diseases, including epidemic-prone diseases and certain non-transmissible diseases. Using the various IDSR forms, information on these disorders is reported through this system. The Epidemiology Division of the Ministry's Department of Public Health is responsible for IDSR activities and conducts surveillance on the 40 most important diseases to public health, as well as providing weekly updates. Similar to the HMIS, the reporting channel is comprised of health facilities. This is reinforced with questionnaires. However, information is frequently limited in breadth and rarely contains private sector statistics.</p> <p>Neither co-morbidities (including mental health problems like depression) nor debilitating impairments are captured by this method.</p> <p>Other school-based and community NTD interventions are documented using treatment registers at service delivery points and summarised using level 1, level 2, level 3, and level 4 forms at the community, health care facility, local government, and state levels, respectively. At the federal office, the NTD data are currently housed on an Excel-based platform.</p> <p>Efforts are being made to switch from paper to electronic reporting of NTD treatment utilising the DHIS2 platform. At all levels, additional investment is required to build capacity and acquire the necessary infrastructure to facilitate this change. The reporting mechanisms and data flow for additional NTDs of priority in Nigeria classified as Innovative disease management NTDs are fragmented and uncoordinated, resulting in inadequate data for policy decision making.</p> |
|----------------------------------|---|

|                         |  |
|-------------------------|--|
| <p>Medical Products</p> | <p>Nigeria does not manufacture drugs for the prevention and treatment of NTD. Instead, the country receives donations from organisations such as the Mectizan Donation Program, GlaxoSmithKline, and Klein, Pfizer, Johnson, and Johnson, which are facilitated by WHO. However, Nigeria has an in-country control and regulatory agency. The National Agency for Food and Drug Administration and Control (NAFDAC) regulates and controls the quality and standards of all imported drugs and drugs produced in the country. Also, it regulates commodities such as foods, cosmetics, medical devices, etc. The medicines are critical to the control and elimination of NTDs and related morbidities.</p> <p>Common NTD medicines include Ivermectin (Mectizan), Albendazole, Praziquantel, Mebendazole, and Azithromycin. Medicine availability is critical to the success of the NTD program, and it is critical that all stakeholders collaborate to avoid delays in medicine clearance at the border as well as theft at state stores.</p>  |
| <p>Health financing</p> | <p>Health Financing in Nigeria is from a variety of sources that include budgetary allocations from Government at all levels (Federal, States and Local), loans and grants, private sector contributions and out of pocket expenses. From 2015 to 2020, the government health expenditure reduced from 16.4% to 15% while household out of pocket expenditure increase from 71.9% to 74.7% (Worldbank 2019)</p> <p>The financing agents of health care in Nigeria, through whom funds are channelled to providers include public agents (Federal ministries and agencies, SMOHs, Hospital management boards, LGAs health departments), National Health Insurance for the formal sector and pilot community health insurance schemes, NGOs and Faith based organizations, private firms' medical units and direct expenditure by household.</p> <p>At the Federal level NTD programme operational budget allocation from 2015-2022 was nine hundred and thirty-four million, five hundred and forty thousand, six hundred and thirty two naira (934,540,632) however, 299,351,526 (32.03%) was released.</p> <p>Funding support for NTDs at the state level is also very poor with no record of funding allocation to NTDs at the local government level.</p> |

|   |   |
|---|---|
| <p><b>Leadership and Governance</b></p> | <p>The Federal Minister of Health leads and directs health sector activities. The Health Minister of state for Health assists him. The Permanent Secretary is the ministry's accounting officer and administrator. The Ministry has Director-led departments. The Department of Public Health's NTD Division is responsible for controlling, eliminating, and eradicating NTDs (see the organogram of the Federal Ministry of Health below). There is a national policy on NTDs that gives guidelines for controlling/eradicating/eliminating these diseases. The Federal Ministry of Health will coordinate the control of NTDs with NGOs, UN agencies, other stakeholders, and the commercial sector, according to its policy statement. The National Health Act (2014) guides health leadership and governance. It tackles all health system building blocks and presents guidance for improving service delivery at all levels.</p> <p>At the national level, a national coordinator manages the NTD secretariat and is assisted by program-specific managers/coordinators. NTD Steering Committee oversees countrywide programme implementation. In the Steering Committee, key line ministries and government agencies collaborate with the Ministry of Health on NTD programme activities. A national NTD task force made up of implementing partners helps coordinate programme activities.</p> |
|---|---|

### 1.3 GAP ASSESSMENT

The World Health Organization (WHO) has prioritized 20 neglected tropical diseases that result from four different causative pathogens:

- Protozoa (human african trypanosomiasis [sleeping sickness], Leishmaniasis)
- Bacteria (buruli ulcer, leprosy [hansen disease], trachoma, yaws)
- Helminth (lymphatic filariasis, onchocerciasis [river blindness], schistosomiasis, soil-transmitted helminthiasis), and
- Virus (rabies)

Though not initially listed as one of the NTDs snakebite envenoming, is believed to be a significant health problem especially in some countries located in the myare believed not to be of significant public health concern.

Currently, the Federal Ministry of Health are addressing the following NTDs based on outcomes of mapping surveys, case searches or high-suspicion index:

1. Preventive Chemotherapy NTDs: Lymphatic Filariasis, Onchocerciasis, Schistosomiasis, Soil Transmitted Helminths, and Trachoma.
2. Case-Management NTDs: Leprosy, Buruli Ulcer, HAT, GWD, Lymphoedema, Trichiasis, Rabies, Leishmaniasis, Yaws,

#### 1.3.1.1 Onchocerciasis

Onchocerciasis is a parasitic disease caused by infection of *Onchocerca volvulus*. In Nigeria, the parasite is transmitted to humans by bites of *Simulium damnosum* (blackflies) that breed in fast flowing rivers and streams. In human hosts, the adult worms of *O. volvulus* live in subcutaneous nodules.

### Situational Analysis

Nigeria is the most endemic country in the world accounting for about 40% of the global prevalence. Millions of Nigerians living in 36,000 communities in 413 LGAs of 32 States and FCT were estimated to be at risk of the disease. There is considerable evidence that onchocerciasis can be eliminated with MAM using Ivermectin.

Treatment of onchocerciasis with ivermectin has been ongoing for two decades in Nigeria with different States at different stages of interventions. In some places where treatment has been ongoing consistently there is evidence that the transmission status has changed significantly. One of the strategies to evaluate and monitor the success of elimination of onchocerciasis is OVI6 analysis of Dried Blood Samples in children <10 years (minimum of 3,000 children per transmission zone/State). In addition to entomological evaluation of 6000 female blackflies per zone subjected to PCR analysis.

Onchocerciasis has been eliminated in Plateau and Nasarawa States and interrupted in eight (8) States (Zamfara, Delta, Kaduna and Kebbi, Imo, Abia, Enugu, Anambra). Leading to over 29 million persons no longer in need of treatment across 108 LGAs.

The disease transmission is suspected to be interrupted in 11 states (Bauchi, Oyo, Ekiti, Ebonyi, FCT, Benue, Jigawa, Yobe, Sokoto, Gombe, Cross River), requiring entomological evaluation.

Onchocerciasis elimination is on track in 9 States (Adamawa, Taraba, Kano, Niger, Kwara, Kogi, Osun, Ondo and Edo States) Osun has collected DBS samples while the other states await collection while transmission is ongoing in 1 State (Ogun), requiring the collection of DBS for Ov-16 analysis.

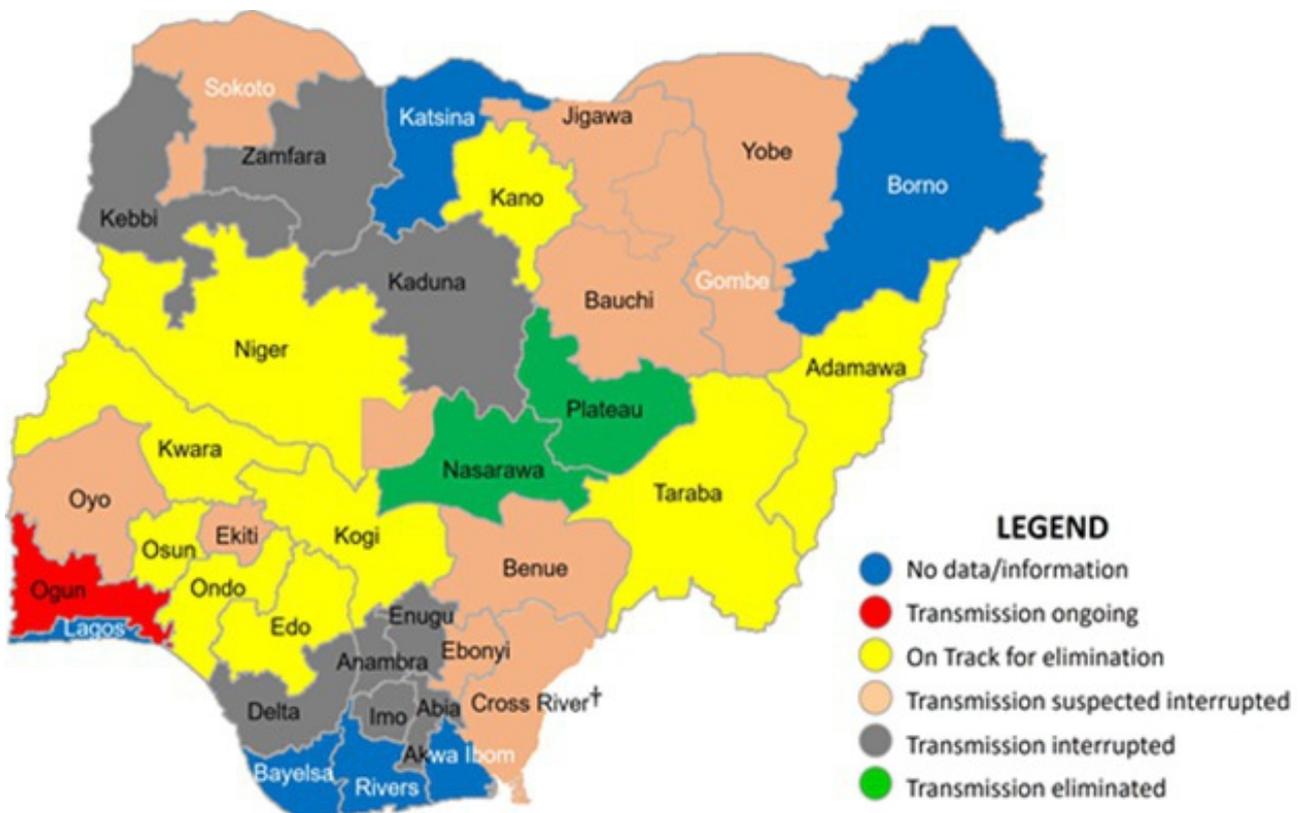
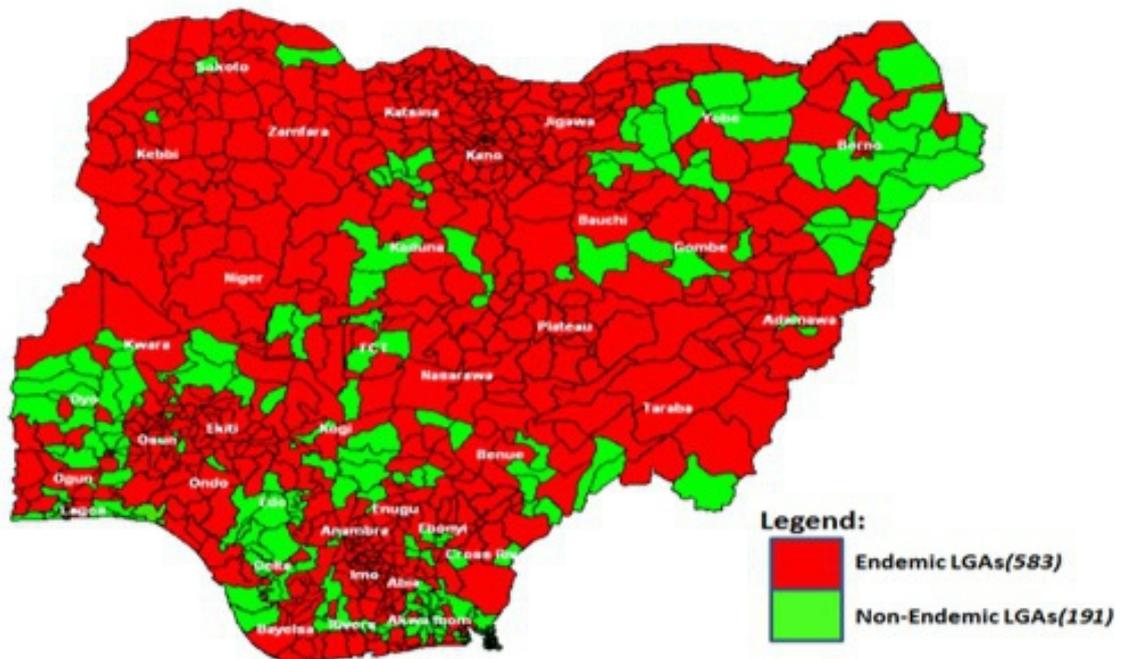


Fig 1: Nigeria Onchocerciasis Elimination December 2022.

### 1.3:2 Lymphatic Filariasis

The National Lymphatic Filariasis Elimination Programme (NLFEP) was established in 1997 with the mandate of eliminating LF as a public health problem. Nigeria has an estimated at-risk population of 141 million people (JRSM 2022). The strategies used were mass administration of medicines (MAM) with ivermectin (3 mg) donated by Mectizan Donation Program (MDP) and albendazole (400 mg) donated by GlaxoSmithKline (GSK) and given annually; morbidity management and disability prevention (MMDP); 583 of the 774 LGAs endemic for LF at baseline have received at least one round of effective treatment, and 139 LGAs (>20.8 million people) There was no mapping gap (all 774 local government areas were mapped); developed national LF assessment guidelines; developed draught national LF MMDP guidelines; and developed LF dossier. 139 LGAs (>20.8 million people) stopped LF treatment in 19 states. 583 endemic LGAs (100%) have received at least one round of LF treatment. A total of 3,442 lymphoedema cases and 7,195 hydrocele cases have been reported in 30 states and the FCT. Out of this, 73.2% of lymphoedema cases have been managed and 64.1% of hydrocele cases have been managed in 17 and 22 states, respectively.



Source: NLFEP, NTDS Division  
Dept of Public Health, FMOH Nigeria

Fig 2a: Lymphatic Filariasis status in Nigeria (2022).

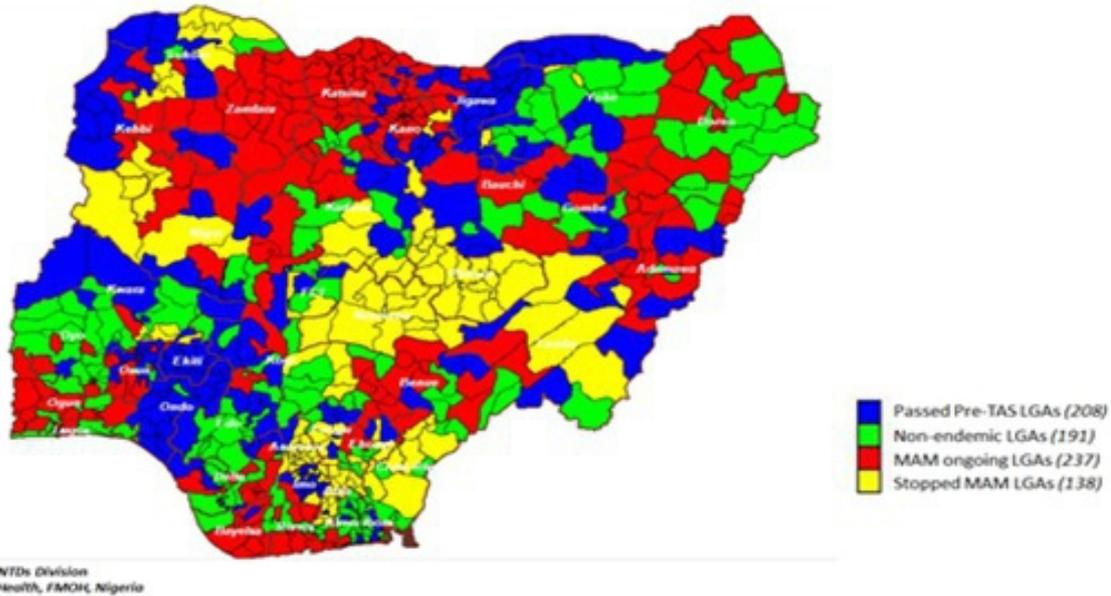


Fig 2b: Lymphatic Filariasis endemicity map by LGA in Nigeria (2018)

### Hydrocele and lymphoedema

Hydrocele is a fluid collection within the Tunica vaginalis of the scrotum, while lymphoedema is a collection of fluid because of lymph vessel dilation that causes swelling (oedema) in the arms and legs. There are seven stages; stage one is reversible, while the other stages are not reversible without management. As of November 2022, a total of 375 LGAs reported cases of lymphoedema and hydrocele, spread across 30 states and the FCT. There were a total of 7195 hydrocele cases and 3442 lymphoedema cases from these states. Between 2016 and 2022, 4,609 cases of hydrocele were treated, while 2,521 cases of lymphoedema were managed.

#### 1.3.3. Schistosomiasis

Schistosomiasis (or blood fluke infection) is caused by trematodes belonging to the genus *Schistosoma*. Three types of this worm cause human schistosomiasis, two of which occur in Nigeria. These are *Schistosoma haematobium*, which causes urinary Schistosomiasis, and *Schistosoma mansoni*, which causes intestinal Schistosomiasis. The Schistosomiasis Programme was founded in 1988 with the mission of assessing the burden of Schistosomiasis and controlling or eliminating the disease among school-age children through prevalence surveys, policy and guidelines development, advocacy, health education and promotion, snail control using safe molluscicides, WASH interventions, and mass treatment with PQZ tablets in all endemic communities.

Mapping surveys for schistosomiasis (*Schistosoma haematobium*) started in 1999 in Plateau and Nasarawa States, supported by the Carter Center and state ministries of health. There was a mapping scale-up between 2013 and 2017, with 773 mapped out of 774 LGAs; 582 LGAs are endemic for the disease.

Preventive chemotherapy for schistosomiasis with praziquantel before now was done through mass drug administration (MDA) at the local government area (LGA) level. This treatment approach, however, had limitations as treatments were conducted on a large scale, reaching areas that did not require treatment, which amounted to medicine wastage. In some instances, wards (sub-districts) that required treatment due to their prevalence were missed, resulting in ineffective rounds of treatment. These challenges necessitated the treatment strategy revision by WHO from LGA level to ward level. Based on this revision, the LGA endemicity data was disaggregated into ward-level data in 2020, where 6,363 wards are currently endemic. Although treatment has been ongoing across these endemic LGAs, achieving effective coverage, impact assessments have not been conducted in most of the LGAs that are due. Hence, progress could not be measured.

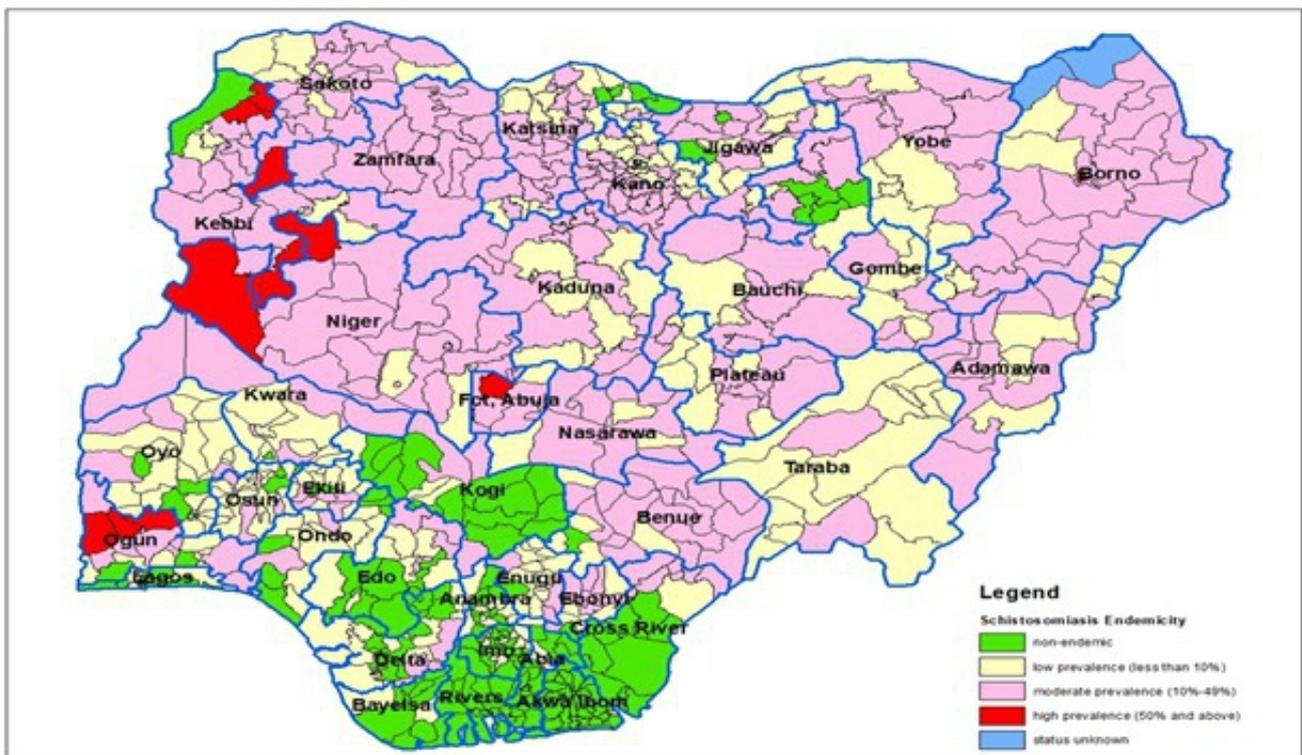


Fig 3. Schistosomiasis Baseline Prevalence Map 2017.

### 1.3.4. Soil Transmitted Helminthiasis

Soil transmitted helminths (STH) are among the Neglected Tropical Diseases that are endemic in Nigeria, and the country is among those with the highest burden of this disease in Africa. The causative agent of soil transmitted helminthiasis includes any of the following worms: *Ascaris lumbricoides*, *Trichuris trichiuria*, *Ancylostoma duodenale*, and *Necator americanus*. It affects mainly children, causing anemia, vitamin A deficiency, malnutrition, loss of appetite, retarded growth, reduced ability to learn, etc. in them.

STH was merged with the Schistosomiasis Programme in 2007 with the mandate to assess the burden of STH infections and to control/eliminate the diseases among school age children through prevalence surveys, policy and guidelines development, advocacy, health education and promotion, WASH interventions, and mass treatment with MEB tablets in all endemic communities. Integrated mapping for soil-transmitted helminths has been conducted in 773 LGAs, of which 429 are endemic for the disease. Prevalence ranged from 0% to 87% in the LGAs mapped. Although treatment has been ongoing across these endemic LGAs, achieving effective coverage, impact assessments have not been conducted in most of the LGAs that are due. Hence, progress could not be measured.

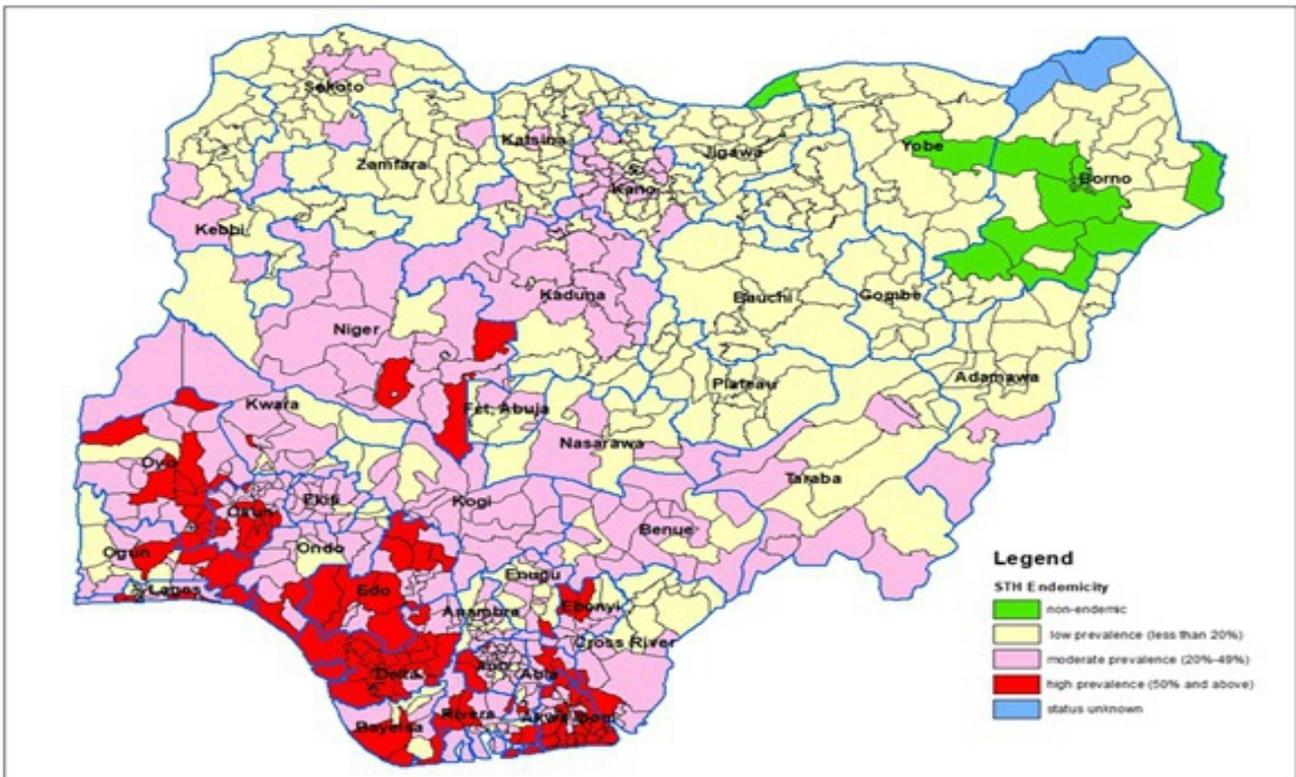


Fig 4: STH Prevalence Map 2010

### 1.3.5. Trachoma

Trachoma is the leading infectious cause of blindness worldwide, caused by a causative agent known as *Chlamydia trachomatis*. The disease is highly prevalent in the northern part of Nigeria, which falls within the Trachoma belt. It is associated with poverty and a low standard of living characterised by overcrowding, poor environmental conditions, and poor personal hygiene.

Mapping of trachoma was conducted in 24 states (453 LGAs), and 126 LGAs were found to be endemic. 10 LGAs (all in Borno State) are yet to be mapped. MDA started in Nigeria in 2010 in 10 LGAs across 5 states (Plateau, Nasarawa, Kebbi, Sokoto, and Zamfara). MDA was scaled up from these 10 LGAs in 2010 to 122 endemic LGAs in 2020. A total of 103 LGAs had stopped MDA. conducted impact and surveillance surveys in 121 and 65 LGAs, respectively.

Nigeria is now the fourth most endemic country for trachoma in the world (after Ethiopia, the DRC, and Cote d'Ivoire), as against second in 2016. At inception, about 30 million people were at risk of going blind from trachoma, but the risk has now been brought down to about 3.5 million, a reduction of 84%. The 3.5 million persons no longer in need of MDA for trachoma are in 103 endemic LGAs in 16 states (Bauchi, Benue, Ebonyi, Edo, Jigawa, Kaduna, Kano, Katsina, Kebbi, Nasarawa, Niger, Plateau, Sokoto, Taraba, Yobe, and Zamfara).

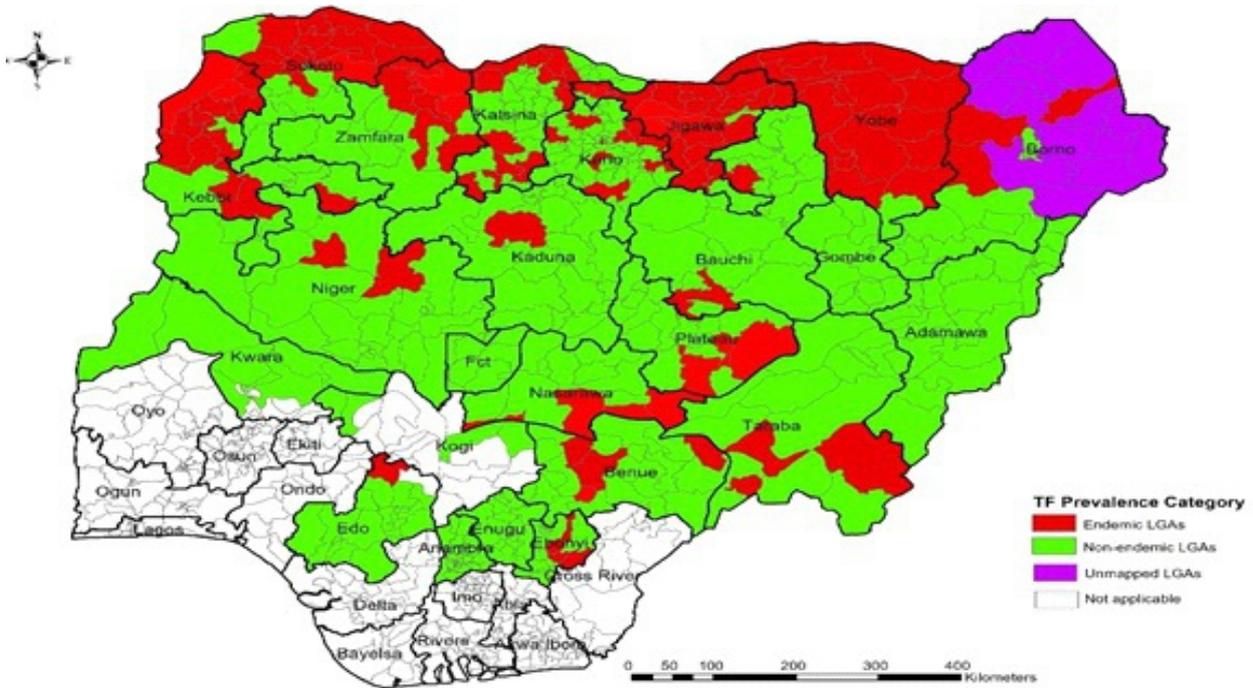


Fig 5: Trachoma Prevalence Map (2021).

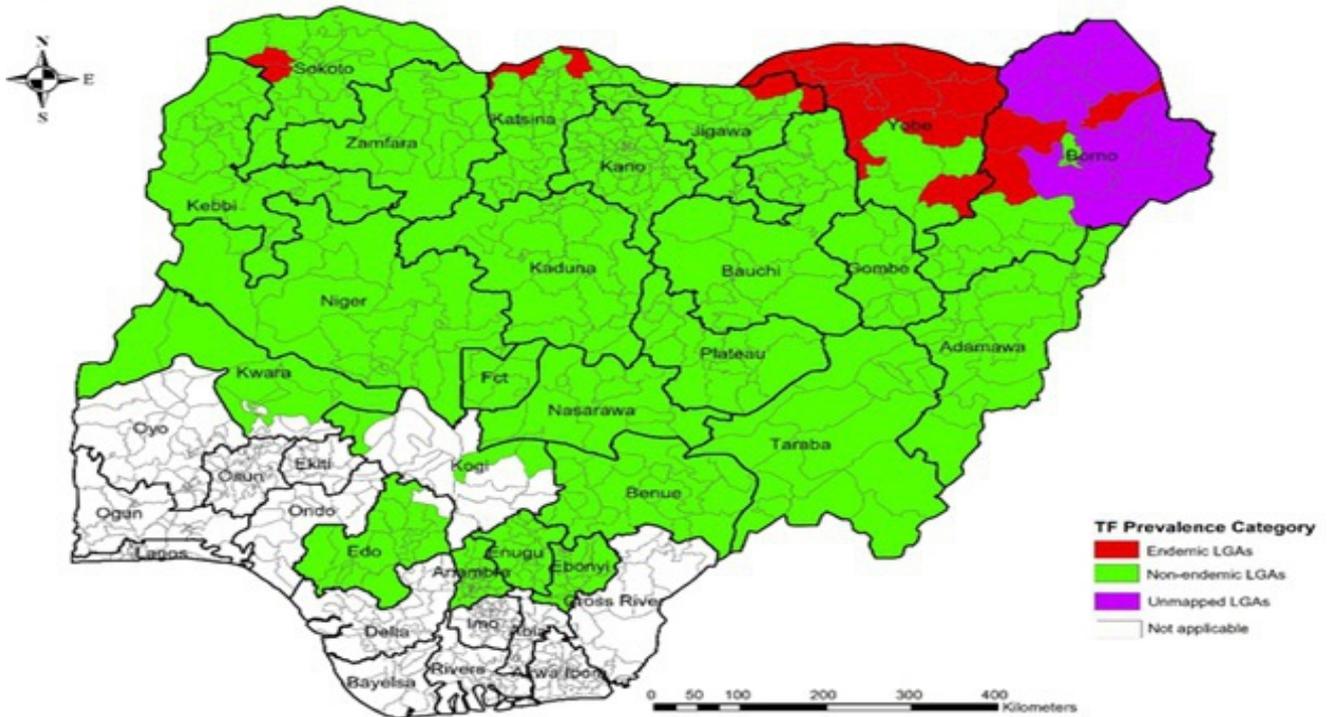


Fig 6: Map showing level of implementation end of 2021

## Surgical Burden in Nigeria June. 22

| State        | Estimated Backlog of trichiasis | Estimated cases remaining since last survey | Estimated cases remaining after sweeping |
|--------------|---------------------------------|---|--|
| Adamawa      | 3,205                           | 70  | 70                                       |
| Bauchi       | 28,330                          | 13,095                                      | 3,304                                    |
| Benue        | 1,790                           | 340   | 8  |
| Borno        | 14,243                          | 9,652                                       | 9,652                                    |
| Edo          | 1,169                           | 273   | 273                                      |
| Ebonyi       | 886                             | 5   | 5  |
| FCT          | 1,054                           | 64  | 0  |
| Gombe        | 19,548                          | 15,711                                      | 15,711                                   |
| Jigawa       | 21,633                          | 13,730                                      | 4,149                                    |
| Kaduna       | 7,058                           | 2,322                                       | 0  |
| Kano         | 36,665                          | 12,732                                      | 7,278                                    |
| Katsina      | 28,364                          | 14,493                                      | 3,540                                    |
| Kebbi        | 9,820                           | 5,322                                       | 4,357                                    |
| Nasarawa     | 1,348                           | 0   | 0  |
| Niger        | 2,336                           | 327   | 327                                      |
| Plateau      | 1,272                           | 0   | 0  |
| Sokoto       | 11,691                          | 6,206                                       | 2,784                                    |
| Taraba       | 3,440                           | 1,082                                       | 1,082                                    |
| Yobe         | 13,128                          | 5,646                                       | 1,613                                    |
| Zamfara      | 5,659                           | 2,333                                       | 916                                      |
| <b>Total</b> | <b>212,639</b>                  | <b>103,403</b>                              | <b>55,069</b>                            |

Table 2 showing the surgical burden of Trichiasis in Nigeria, June 2022

### 1.3.6. Human African Trypanosomiasis

Human African Trypanosomiasis is a vector-borne parasitic disease; the parasite is *Trypanosoma brucei*, and the vector is the tsetse flies of the genus *Glossina*. The passive screening was only done in one out of the thirty-six states of the Federation. Support is needed for the passive survey in the six geopolitical zones of the country. There has been no confirmed case since 2016, and thus no treatment.

The difficulties facing HAT elimination activity are a lack of funds and support to scale up vector control strategies and logistical support. Priorities to be set for HAT elimination include training of personnel on HAT diagnosis and management; passive surveillance in all the 'at-risk sites' (i.e., villages that share a boundary with the Ethiope river in Edo state); active surveillance in Abraka, Eku, and the villages bordering the Ethiope river; supply of kits to the sites where passive surveillance had stopped; and support for monitoring all the passive sites at least quarterly.

### 1.3.7. Guinea worm disease

Nigeria was among the top three endemic countries in the world at the time the Guinea worm eradication programme was launched in the country in 1988. The global campaign to eradicate GWD was enunciated within the framework of the United Nations International Drinking Water Supply and Sanitation Decade (1981–1991). It is in this context that Nigeria launched the Nigeria Guinea worm

eradication programme (NIGEP). During the case search in 1988-1989, Nigeria reported over 653,000 cases of Dracunculiasis (Guinea worm disease (GWD)). Nigeria entered the pre-certification phase and fulfilled WHO criteria for certification, followed by the inauguration of the National Certification Committee on Guinea Worm Disease Eradication (NCC-GWDE) in May 2005. Nigeria was certified as a GWD-free country in December 2013. The goal has been to strengthen surveillance systems to maintain the guinea worm-free status of the country and establish and sustain mechanisms for containing transmission

### 1.3.8. Leprosy

Leprosy is a chronic infectious disease of man that affects mainly the skin, mucous membranes, and peripheral nerves. Nigeria is among the seventeen countries in the world that are still reporting more than 1,000 new cases of leprosy annually. Despite achieving the World Health Organization's (WHO) leprosy elimination target of less than 1 per 10,000 population at the national level in 1998, many pockets of significant leprosy endemicity remain at the sub-national level across the country. These pockets are mostly located in 15 states (Akwa Ibom, Adamawa, Bauchi, Benue, Borno, Cross River, Ebonyi, Jigawa, Kaduna, Kano, Kebbi, Kogi, Niger, Taraba, and Zamfara).

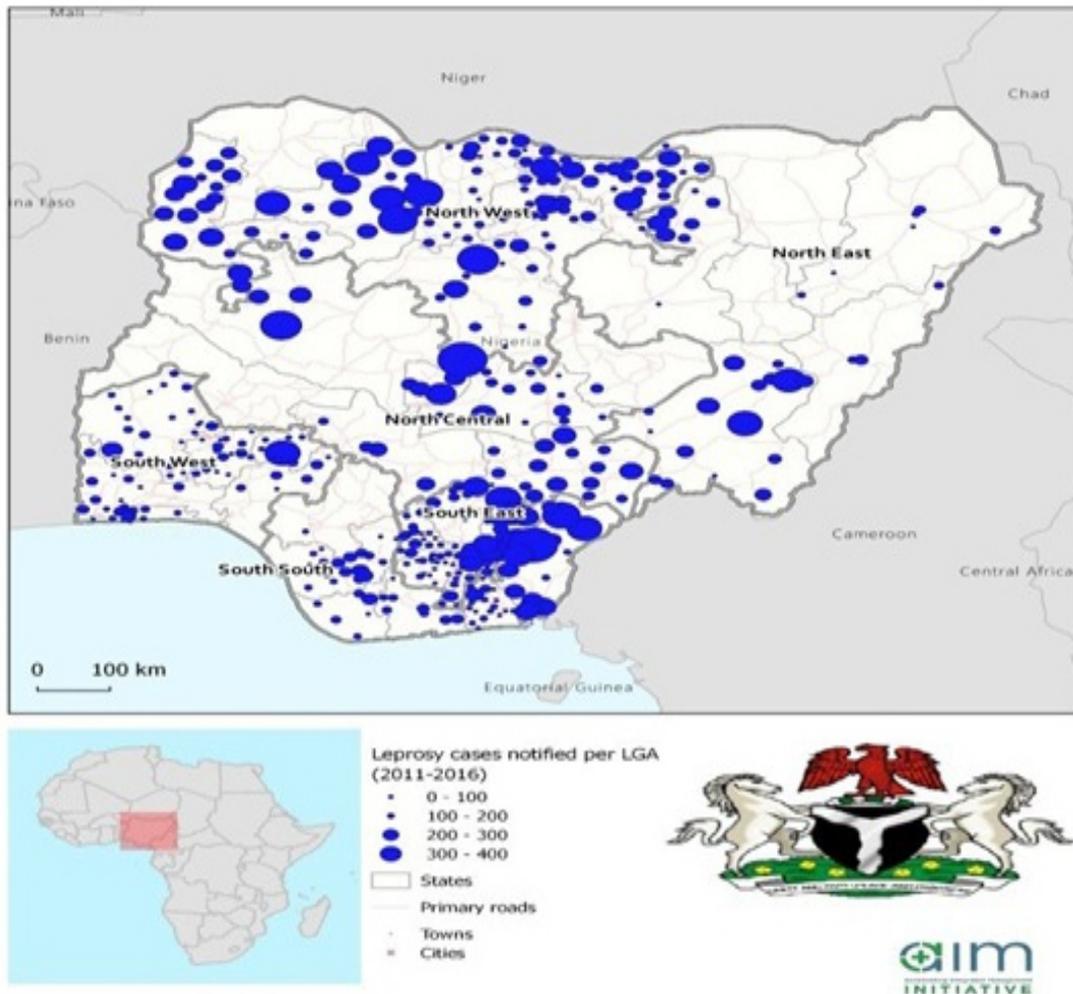


Fig 7: Leprosy cases notified per LGA 2016.

Even after completing multi-drug therapy (MDT), leprosy remains a leading cause of permanent physical disability, causing stigma, isolation, and destitution in affected individuals. The implementation of MDT as the strategic intervention to eliminate leprosy has resulted in a rapid decline in the number of new leprosy cases detected, from nearly 200,000 in 1989 to 2687 in 2016. The table below shows the trend of leprosy

epidemiological data in Nigeria from 2011 to 2021 (table 3). Although there is a gradual decline in new leprosy cases detected, especially from 2013 to 2016, the high Grade 2 disability rate and child proportion, which signifies late case detection and on-going transmission, is worrisome. The decline in leprosy cases detected could be a result of poor skills among frontline health workers, inadequate funding due to weak political commitment, and the economic meltdown that affected the resources of the few existing donors. The available data also implies the existence of clusters of leprosy endemicity at the sub-national level. Some of these clusters have already been identified in the current mapping by the FMOH. The need to design strategic interventions to address leprosy in these clusters is of great relevance to on-going control efforts.

The National Tuberculosis, Leprosy, and Buruli Ulcer Control Programme (NTBLCP) was established in 1989 and launched in 1991 with the mandate to ensure the control of TB, leprosy, and BU in Nigeria. NTBLCP operates in all 774 local government areas in the 36 states and the Federal Capital Territory of Nigeria. The International Federation of Anti-Leprosy Associations (ILEP) Partners, which include the German Leprosy and TB Relief Association (GLRA), until No Leprosy Remains (NLR), the Damien Foundation (DFB), and The Leprosy Mission Nigeria (TLMN), provide support for leprosy activities.

| Year | Total New cases | MB    | PB  | G2D       | Under 15 | Treatment completion rate |      |
|------|-----------------|-------|-----|-----------|----------|---------------------------|------|
|      |                 |       |     |           |          | MB                        | PB   |
| 2021 | 2,398           | 2,326 | 72  | 270(11%)  | 212(9%)  | 97%                       | 100% |
| 2020 | 1,559           | 1,528 | 31  | 178(11%)  | 87(6%)   | 98%                       | 100% |
| 2019 | 2,424           | 2,085 | 339 | 369(15%)  | 276(11%) | 86%                       | 100% |
| 2018 | 2,095           | 2,011 | 84  | 306(15%)  | 125(6%)  | 96%                       | 100% |
| 2017 | 2,447           | 2,202 | 245 | 361(15%)  | 184(8%)  | 90%                       | 100% |
| 2016 | 2,687           | 2,553 | 137 | 377(14%)  | 174(6%)  | 95%                       | 100% |
| 2015 | 2,891           | 2,754 | 137 | 447(15%)  | 265(9%)  | 92%                       | 100% |
| 2014 | 2,983           | 2,744 | 239 | 388 (13%) | 268 (9%) | 92%                       | 100% |
| 2013 | 3,385           | 3,148 | 237 | 440 (13%) | 305(9%)  | 92%                       | 100% |
| 2012 | 3,805           | 3,501 | 304 | 533(14%)  | 342(9%)  | 91%                       | 100% |
| 2011 | 3,623           | 3,333 | 290 | 507 (14%) | 326 (9%) | 90%                       | 100% |

TABLE 3: NTBLCP Epidemiological Data of Leprosy 2011 to 2021

**Trend in Leprosy cases in Nigeria 2011-2021 – Nigeria is among countries detecting over 1,000 new Leprosy cases annually**

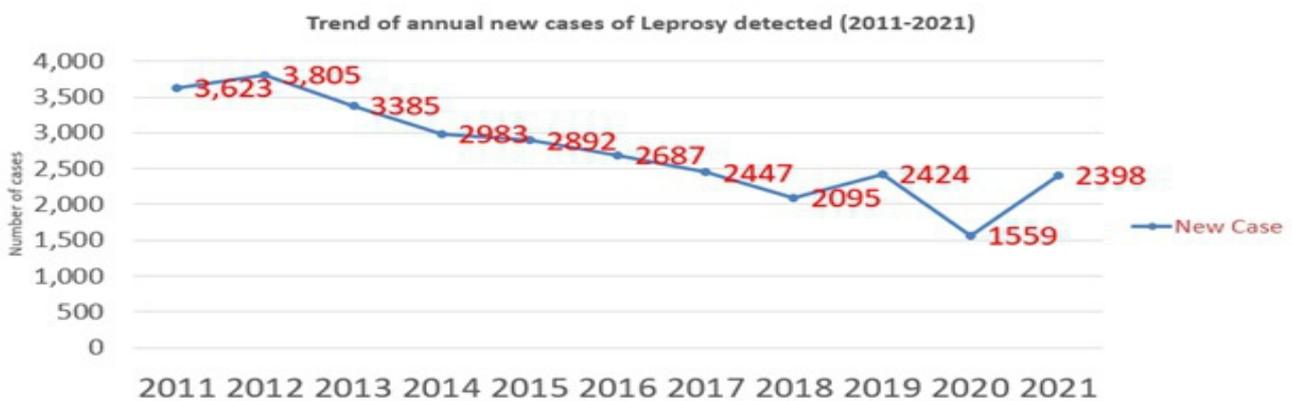


Fig 8: Trend in Leprosy cases in Nigeria 2021.

### 1.3.9. Buruli Ulcer

Buruli ulcer (BU), is a devastating skin disease caused by *Mycobacterium ulcerans*. It is one of the most neglected but treatable tropical diseases. The causative organism is from the family of bacteria that causes tuberculosis and leprosy, but Buruli ulcer has received less attention than these diseases. The incubation period is 1–9 months (avg. 4.5 months). Infection leads to extensive destruction of skin and soft tissue and the formation of large ulcers, usually on the legs or arms. Patients who are not treated early often suffer from long-term functional disabilities such as joint restriction. early detection and treatment are critical in the prevention of such disabilities.

Nigeria was established as a BU-endemic country by the WHO in 2006. The chart below shows an 11-year trend in BU case detection in Nigeria between 2011 and 2021.

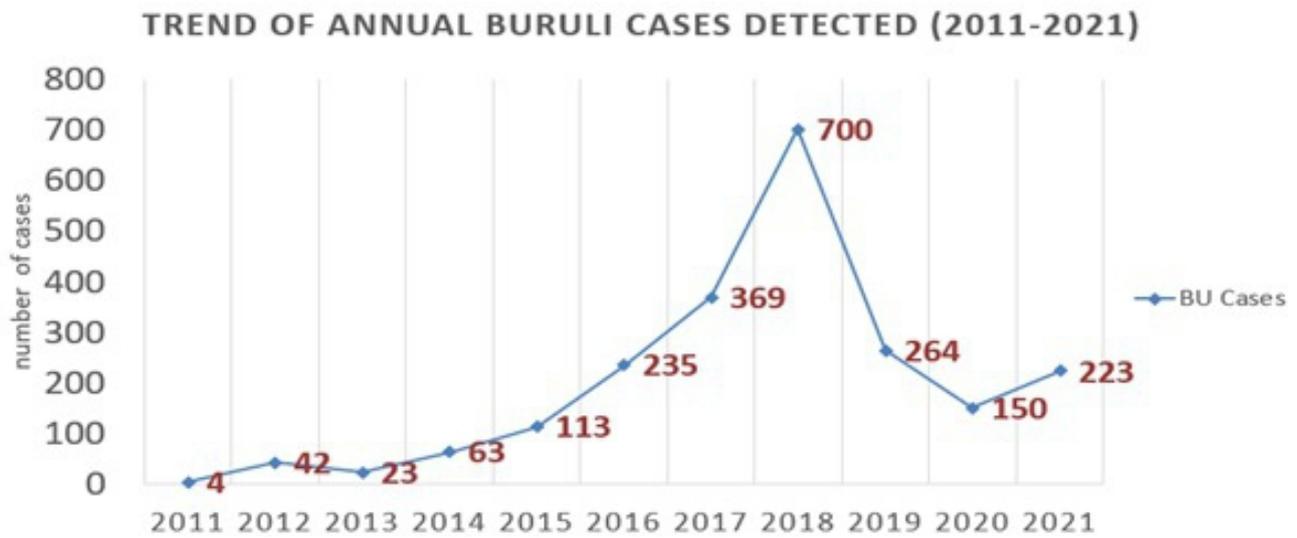


Fig 9: Trend of Annual Buruli Case Detected (2021).

### 1.3.10. Rabies

Nigeria is faced with an increasing zoonotic disease burden; at the recently concluded Zoonotic Disease Prioritization (ZDP) workshop in Nigeria, these diseases were prioritised for proper attention Rabies, highly pathogenic avian influenza (HPAI), bovine tuberculosis, Lassa fever, monkey pox, and Brucellosis Rabies stands out among these diseases. It is a prioritised disease. Rabies is a highly infectious disease of all warm-blooded animals and humans caused by rhabdoviruses (genus *Lyssa virus*). It is transmitted through the bites of infected animals and humans. It can kill 100% of its infected victims without timely and efficient postexposure prophylaxis (treatment). Despite the high fatality rate of the disease, it is 100% vaccine preventable. In December 2015, the Tripartite Quadripite of FAO, WHO, and OIE UNEP set a global agenda to end dog-mediated human rabies by the year 2030 and produced a Step Wise Approach towards Rabies Elimination (SARE) tool to enable countries to plan, monitor, and evaluate their progress towards the goal of eliminating dog-mediated human rabies, which requires multisectoral and multidisciplinary collaborations, also known as One Health (OH), in the designing and implementation of programs, policies, legislation, and research. Nigeria formally launched its One Health (OH) strategic plan in December 2019, and implementation is ongoing. The strategy was designed to build a strategic, dynamic, and functional platform that advances human, animal, and environmental health through multidisciplinary and intersectoral collaboration.

In Nigeria, the Tripartite Quadripartite is the Federal Ministry of Agriculture and Rural Development, the Federal Ministry of Health, the Federal Ministry of Environment, and their agencies. The OH platform was successfully used to control COVID-19 and it was cost effective, demonstrating that OH can be used to achieve cost effectiveness and that one sector cannot do it alone. Rabies has been reported in Nigeria since 1912, with documented cases of latent rabies in recent times. The disease has been reported in dogs, cats, cattle, sheep, goats, horses, donkeys, and wildlife. Several human cases have also been reported, especially among schoolchildren and women. The reported incidence of rabies is on the increase annually, and this can be due to dog owners' ignorance about the dangers of rabies, a lack of public awareness about proper dog keeping, and the high cost of vaccines. 40% of people bitten by suspected rabid animals are children under 15 years of age. In many developing countries, rabies control programmes are not a high priority on the government's agenda.

The Global Alliance for Rabies Control (GARC) supported Nigeria through FMARD to develop a joint national rabies work plan (NRWP) in 2022 to be used for implementation until 2030. From the developed plan, a tool was generated that can monitor implementation by each sector, the tool is called Step Wise Approach towards Rabies Elimination (SARE). It has 5 steps from the establishment of the programme to the elimination of the rabies disease, This tool was used to assess Nigeria's extent of implementation, and its score is 1.5. In 2021, FMOH procured 500 doses of anti-rabies vaccine and distributed them to 10 selected states, the selection was based on the frequency of dog bite cases reported. They are Adamawa, Benue, Zamfara, FCT, Ebonyi, Abia, Anambra, Bayelsa, Cross-River, and Plateau. Gombe State has confirmed four human cases of rabies in 2022. Kano, Kebbi, and Anambra also reported dog bite cases that were not investigated, and the status of dog vaccination is not known.

### 1.3.11. Leishmaniasis

This disease is caused by any of a number of species of protozoa in the genus *Leishmania*. There are several major clinical types of this infection including cutaneous, diffuse cutaneous, muco-cutaneous and visceral leishmaniasis. In Nigeria the type that is common is cutaneous leishmaniasis (CL), with evidence of visceral leishmaniasis (VL) being available. CL, also known as oriental or tropical sore, occurs in various parts of the world, mainly in tropical and subtropical regions. In the African continent, CL due to *L. major*, *L. tropica* and *L. aethiopia* is unevenly distributed from the northern to the southern areas of the continent.

A common estimate of the worldwide annual incidence is 600,000 newly reported clinical cases, an overall prevalence of 12 million cases and an estimated population at risk of about 350 million in 88 countries. There is probably an even greater difference between the number of cases actually occurring and the number usually reported due to factors such as discontinuous distribution of transmission sites, numerous cases that are undiagnosed, some misdiagnosed and the number of asymptomatic cases.

Five cases of cutaneous leishmaniasis were recorded in a pilot mapping for the disease conducted in Nasarawa State in 2014. In addition, there are articles by researchers on cutaneous, diffuse cutaneous and visceral leishmaniasis. There is need to conduct mapping of the disease across the entire country to obtain baseline data on its burden and spread in the country.

Cutaneous leishmaniasis was confirmed in 63 of 1,120 suspected cases in a study of school-age children from the Plateau region. A recent house-to-house survey in this area also found CL in 18 (2.6%) of a population of 703 inhabitants. There is a need to scale up mapping to ascertain the prevalence of leishmaniasis.

### 1.3.12. Cutaneous Leishmaniasis



Fig 11: Showing state where Cutaneous Leishmaniasis had been reported (December, 2021).

### 1.3.13. Yaws

Yaws is a contagious, non-venereal treponematoses characterised by a primary skin lesion followed by a chronic stage in which destructive, disfiguring lesions of the skin and bones result in disability. The disease is caused by *Treponema pallidum* subspecies *pertenue*. Humans are the only source of infection, which is transmitted from person to person mainly by direct skin contact with fluid from the primary yaws lesion.

Overcrowding, poor sanitation, and poor personal hygiene also facilitate the spread of the disease. It can also cause deformities of the legs, nose, palate, and upper jaw, and hence should be of major concern to the country, as this will affect human development, which will in turn affect the country economically and otherwise. Since the 1960's, there has not been any intervention in this area about Yaws control measures, surveillance, or any monitoring activity put in place, which means that this disease may have spread or be in a latent state waiting to explode, hence the need for proactiveness to curtail this from happening. The Enugu Ezike, Nigeria, campaign (which began in 1954) used a total mass treatment strategy on 57 000 at-risk people. Yaws (one of the case management NTDs) started as a programme in Nigeria in 2017 with the target of joining other endemic countries to work towards its eradication by 2025.

Within 2017–2022, 19 states reported suspected cases of Yaws; 7 states have been visited by the Federal

Ministry of Health (FMOH) (Yaws unit of NTDs) to detect and confirm these suspected cases with the assistance of WHO and GLRA; and 3 states (Jigawa, Sokoto, and Bauchi) have been found to be harbouring suspected cases of Yaws. As these cases continue to spread locally unnoticed, more states must be combed or searched so that the country can use the WHO's Morge strategy for intervention.



Fig 12: Showing states where Yaws had ben reported (December,2022)

### 1.3.14. Snakebite Envenoming

Snakebite is a major medical problem in rural communities of the Savannah Region of West Africa, notably in Nigeria, Senegal, Ghana, Togo, Benin, Burkina-Faso, Niger, Mali, and Cameroun. Several poisonous snakes have been identified in Nigeria, with three major ones (*Naja nigricolis* (Cobra), *Bitis arietans* (Puff Adder), and *Echis ocellatus* (Carpet Viper) being the most common causes of envenomation). Nigeria's *Echis ocellatus* is the most dangerous in the world.

The estimated incidence of snake bites in Nigeria is 497 bites per 100,000 people per year, according to a 2013 epidemiological survey (Habib 2013). This constituted 1/5 of all African Region cases; 90% of bites and 60% of deaths are caused by the most medically important snake in Nigeria—the carpet viper. Snakebites are occurring mostly in very fertile areas of the country, such as the Benue and Niger River valleys. During peak season (between May and July, when farmers prepare their land for planting) and later during the harvesting period (October-November), half of the beds in some highly affected rural hospitals are occupied by snakebite victims.

Following the 1994–1995 sampled epidemiological survey conducted by the Federal Ministry of Health

to determine the species of snakes in Nigeria and which of them are venomous, the National Council on Health (NCH) set up the EchiTAB Study Group, Nigeria/United Kingdom, in the year 2000 with the mandate to research and develop antivenom specific to Nigerian species of snakes. EchiTab Study Group has been able to export hundreds of Nigeria's most poisonous snakes to the WHO reference centre for poisons and toxins extraction at the Liverpool School of Tropical Medicine since the program's inception. The current burden across the country is shown below.

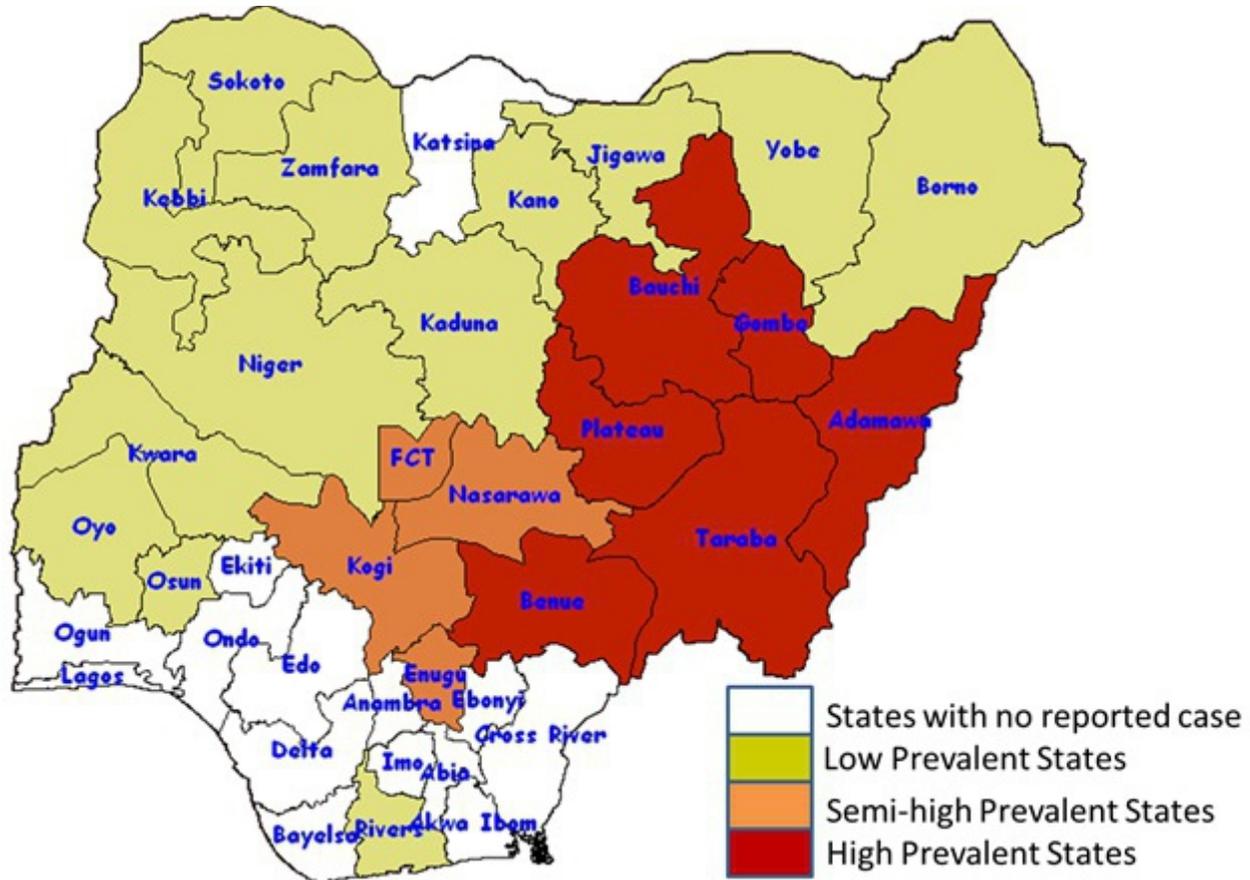


Fig 13: Snakebite Prevalence Map (2013).

**Section 1.4. Programme Context Analysis**

| State     | Number of LGAs | Number of IUs | No. of villages or communities* | Total population | Under- 5 (Pre-school) | 5-14 years (School age) | 15 years and above | No. primary schools | No. of peripheral health facilities |          |                | Number of Health Workers (NTD) | Number of Community Implementers |
|-----------|----------------|---------------|---------------------------------|------------------|-----------------------|-------------------------|--------------------|---------------------|-------------------------------------|----------|----------------|--------------------------------|----------------------------------|
|           |                |               |                                 |                  |                       |                         |                    |                     | Referral                            | IU level | Health Centres |                                |                                  |
| Abia      | 17             | 17            | 3550                            | 4,204,458        | 840,892               | 1,177,248               | 2,186,318          | 1871                | 6                                   | 655      | 958            | 1768                           | 9,321                            |
| Adamawa   | 21             | 21            | 2772                            | 4,700,124        | 940,025               | 1,316,035               | 2,444,065          | 2630                | 1                                   | 0        | 1100           | 189                            | 4922                             |
| Akwa Ibom | 31             | 31            | 2860                            | 5,815,934        | 1,163,187             | 1,628,461               | 3,024,285          | 1,155               | 3                                   | 35       | 574            | 244                            | 5919                             |
| Anambra   | 21             | 21            | 3608                            | 6,204,370        | 1,240,874             | 1,737,224               | 3,226,272          | 2,878               | 3                                   | 567      | 754            | 1025                           | 6285                             |
| Bauchi    | 20             | 20            | 6998                            | 6,937,777        | 1,387,555             | 1,942,578               | 3,607,644          | 3462                | 6                                   | 23       | 1223           | 789                            | 9580                             |
| Bayelsa   | 8              | 8             | 144                             | 2,527,064        | 505,413               | 707,578                 | 1,314,073          | 1262                | 4                                   | 1        | 230            | 260                            | 2000                             |
| Benue     | 23             | 23            |                                 | 6,259,577        | 1,251,915             | 1,752,681               | 3,254,980          | 3751                | 2                                   |          | 1730           |                                |                                  |

TABLE 4: Known disease distribution in Nigeria

|   |     |     |        |             |            |            |             |         |     |      |       |        |         |
|---|-----|-----|--------|-------------|------------|------------|-------------|---------|-----|------|-------|--------|---------|
| Borno   | 27  | 27  | 7272   | 6,158,618   | 1,231,724  | 1,724,413  | 3,202,481   | 1343    | □2  | □    | 378   | 270    | 4651    |
| Cross River   | 18  | 18  | 2119   | 4,286,006   | 857,201    | 1,200,082  | 2,228,723   | 2167    | 6   | 18   | 1150  | 973    | 14017   |
| Delta   | 25  | 25  | 3462   | 6,080,282   | 1,216,056  | 1,702,479  | 3,161,747   | 3003    | 2   | 30   | 647   | 698    | 5437    |
| Ebonyi  | 13  | 13  | 1739   | 3,224,558   | 644,912    | 902,876    | 1,676,770   | 1788    | □2  | □    | 700   | 667    | 3968    |
| Edo   | 18  | 18  | 2527   | 4,774,646   | 954,929    | 1,336,901  | 2,482,816   | 2107    | 9   | 0    | 900   | 747    | 4301    |
| Ekiti   | 16  | 16  | 422    | 3,536,284   | 707,257    | 990,160    | 1,838,868   | 1,882   | 3   | 0    | 458   | 639    | 366     |
| Enugu   | 17  | 17  |        |             |            |            |             |         | 8   |      |       |        |         |
|   |     |     | 6407   | 4,832,455   | 966,491    | 1,353,087  | 2,512,877   | 2161    |     | 7    | 644   | 976    | 3384    |
| FCT   | 6   | 6   | 559    | 2,084,725   | 416,945    | 583,723    | 1,084,057   | 1572    | 8   | 150  | 485   | 281    | 2200    |
| Gombe   | 11  | 11  | 1061   | 3,492,163   | 698,433    | 977,806    | 1,815,925   | 1967    | 1   | 12   | 618   | 3333   | 12380   |
| Imo   | 27  | 27  | 5325   | 5,837,729   | 1,167,546  | 1,634,564  | 3,035,619   | 2813    | 2   | 588  | 821   | 1474   | 12,848  |
| Jigawa  | 27  | 27  | 9334   | 6,451,559   | 1,290,312  | 1,806,437  | 3,354,811   | 2713    | 1   | 1    | 745   | 749    | 9610    |
| Kaduna  | 23  | 23  | 6766   | 9,000,217   | 1,800,043  | 2,520,061  | 4,680,113   | 5161    | 20  | 24   | 1275  | 821    | 15894   |
| Kano  | 44  | 44  | 6514   | 13,921,422  | 2,784,284  | 3,897,998  | 7,239,140   | 7129    | 6   | 128  | 1335  | 1200   | 20,343  |
| Katsina   | 34  | 34  | 5922   | 8,593,740   | 1,718,748  | 2,406,247  | 4,468,745   | 3566    | 3   | 53   | 1901  | 1826   | 7223    |
| Kebbi   | 21  | 21  | 3761   | 4,804,757   | 960,951    | 1,345,332  | 2,498,473   | 3281    | 2   | 27   | 885   | 1243   | 11,722  |
| Kogi  | 21  | 21  | 3148   | 4,863,891   | 972,778    | 1,361,889  | 2,529,223   | 3046    | 3   | □    | 1079  | 1291   | 5 193   |
| Kwara   | 16  | 16  | 1451   | 3,517,695   | 703,539    | 984,955    | 1,829,201   | 3022    | 3   | 14   | 781   | 1553   | 4600    |
| Lagos   | 20  | 20  | 2790   | 13,372,273  | 2,674,455  | 3,744,236  | 6,953,582   | 9,689   | 7   | 25   | 1520  | 133    | □       |
| Nasara wa   | 13  | 13  | 1052   | 2,764,313   | 552,863    | 774,008    | 1,437,443   | 2801    | 2   | 65   | 987   | 582    | 1044    |
| Niger   | 25  | 25  | 6881   | 5,860,502   | 1,172,100  | 1,640,940  | 3,047,461   | 4,765   | 3   | 15   | 1,497 | 1350   | 11040   |
| Ogun  | 20  | 20  | 9795   | 5,530,923   | 1,106,185  | 1,548,659  | 2,876,080   | 4797    | 2   | 41   | 999   | 738    | □       |
| Ondo  | 18  | 18  | 1488   | 5,105,027   | 1,021,005  | 1,429,408  | 2,654,614   | 2765    | 4   | 118  | 721   | 820    | 10603   |
| Osun  | 30  | 30  | 1768   | 5,079,081   | 1,015,816  | 1,422,143  | 2,641,122   | 3327    | 6   | 1056 | 1009  | 1055   | 12180   |
| Oyo   | 33  | 33  | 7674   | 8,295,557   | 1,659,111  | 2,322,756  | 4,313,690   | 5312    | 5   | 673  | 890   | 2107   | 6686    |
| Plateau   | 17  | 17  | 2577   | 4,715,867   | 943,173    | 1,320,443  | 2,452,251   | 3521    | 5   | 878  | 1323  | 328    | 2715    |
| Rivers  | 23  | 23  | 3418   | 7,692,944   | 1,538,589  | 2,154,024  | 4,000,331   | 2702    | 6   | 0    | 459   | 105    | 0       |
| Sokoto  | 23  | 23  | 6385   | 5,484,786   | 1,096,957  | 1,535,740  | 2,852,089   | 2241    | 3   | 24   | 797   | 2001   | 3503    |
| Taraba  | 16  | 16  | 2313   | 3,383,274   | 676,655    | 947,317    | 1,759,302   | 2821    | 1   | 16   | 902   | 885    | 6288    |
| Yobe  | 17  | 17  | 1109   | 3,444,261   | 688,852    | 964,393    | 1,791,016   | 1167    | 2   | 11   | 558   | 499    | 3666    |
| Zamfara   | 14  | 14  | 2864   | 4,836,235   | 967,247    | 1,354,146  | 2,514,842   | 1991    | 2   | 21   | 734   | 698    | 11009   |
|   | 774 | 774 | 137835 | 207,675,093 | 41,535,019 | 58,149,026 | 107,991,048 | 113,814 | 154 | 5276 | 22805 | 34,317 | 239,705 |
| *Where implementation and administrative units are separate (e.g. onchocerciasis interventions), target communities in a district |     |     |        |             |            |            |             |         |     |      |       |        |         |

| State     | No. LGAs | Number of Endemic LGAs |       |     |     |     |     |      |     |               |              |      |     |        |
|-----------|----------|------------------------|-------|-----|-----|-----|-----|------|-----|---------------|--------------|------|-----|--------|
|           |          | LF                     | Oncho | SCH | STH | HAT | Lep | Lesh | TRA | Dracunculosis | Buruli Ulcer | Yaws | SBE | Rabies |
| Abia      | 17       | 17                     | 17    | 5   | 16  | NM  |     | NM   | 0   | 0             |              | NM   | NA  | NA     |
| Adamawa   | 21       | 18                     | 17    | 21  | 2   | NM  |     | NM   | 0   | 0             |              | NM   | NA  | NA     |
| Akwa Ibom | 31       | 11                     | 4     | 1   | 31  | NM  |     | NM   | 0   | 0             |              | NM   | NA  | NA     |
| Anambra   | 21       | 21                     | 16    | 11  | 12  | NM  |     | NM   | 0   | 0             |              | NM   | NA  | NA     |
| Bauchi    | 20       | 11                     | 12    | 16  | 0   | NM  |     | NM   | 2   | 0             |              | NM   | NA  | NA     |
| Bayelsa   | 8        | 7                      | 0     | 2   | 5   | NM  |     | NM   | 0   | 0             |              | NM   | NA  | NA     |

|              |            |            |            |            |            |    |  |    |            |          |  |    |    |    |
|--------------|------------|------------|------------|------------|------------|----|--|----|------------|----------|--|----|----|----|
| Benue        | 23         | 16         | 23         | 22         | 18         | NM |  | NM | 3          | 0        |  | NM | NA | NA |
| Borno        | 27         | 14         | 13         | 27         | 0          | NM |  | NM | 7          | 0        |  | NM | NA | NA |
| Cross River  | 18         | 10         | 15         | 6          | 9          | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Delta        | 25         | 16         | 15         | 14         | 25         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Ebonyi       | 13         | 9          | 12         | 12         | 11         | NM |  | NM | 4          | 0        |  | NM | NA | NA |
| Edo          | 18         | 7          | 16         | 11         | 18         | NM |  | NM | 1          | 0        |  | NM | NA | NA |
| Ekiti        | 16         | 16         | 16         | 15         | 15         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Enugu        | 17         | 14         | 15         | 16         | 10         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| FCT          | 6          | 4          | 6          | 6          | 2          | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Gombe        | 11         | 10         | 10         | 11         | 0          | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Imo          | 27         | 27         | 22         | 8          | 25         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Jigawa       | 27         | 27         | 17         | 25         | 0          | 0  |  | NM | 23         | 0        |  | NM | NA | NA |
| Kaduna       | 23         | 18         | 16         | 23         | 14         | NM |  | NM | 1          | 0        |  | NM | NA | NA |
| Kano         | 44         | 44         | 18         | 44         | 17         | NM |  | NM | 10         | 0        |  | NM | NA | NA |
| Katsina      | 34         | 30         | 0          | 30         | 4          | NM |  | NM | 12         | 0        |  | NM | NA | NA |
| Kebbi        | 21         | 20         | 9          | 20         | 2          | NM |  | NM | 14         | 0        |  | NM | NA | NA |
| Kogi         | 21         | 11         | 21         | 7          | 18         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Kwara        | 16         | 11         | 16         | 15         | 12         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Lagos        | 20         | 6          | 0          | 7          | 12         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Nasarawa     | 13         | 13         | 7          | 13         | 4          | NM |  | NM | 4          | 0        |  | NM | NA | NA |
| Niger        | 25         | 19         | 21         | 25         | 22         | NM |  | NM | 2          | 0        |  | NM | NA | NA |
| Ogun         | 20         | 14         | 18         | 18         | 14         | NM |  | NM |            | 0        |  | NM | NA | NA |
| Ondo         | 18         | 17         | 14         | 10         | 14         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Osun         | 30         | 27         | 28         | 27         | 30         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Oyo          | 33         | 10         | 28         | 28         | 32         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Plateau      | 17         | 17         | 6          | 17         | 0          | NM |  | NM | 3          | 0        |  | NM | NA | NA |
| Rivers       | 23         | 13         | 0          | 0          | 21         | NM |  | NM | 0          | 0        |  | NM | NA | NA |
| Sokoto       | 23         | 20         | 1          | 23         | 5          | NM |  | NM | 14         | 0        |  | NM | NA | NA |
| Taraba       | 16         | 13         | 13         | 16         | 8          | NM |  | NM | 3          | 0        |  | NM | NA | NA |
| Yobe         | 17         | 11         | 12         | 17         | 0          | NM |  | NM | 16         | 0        |  | NM | NA | NA |
| Zamfara      | 14         | 14         | 6          | 14         | 1          | NM |  | NM | 7          | 0        |  | NM | NA | NA |
| <b>Total</b> | <b>774</b> | <b>583</b> | <b>480</b> | <b>583</b> | <b>429</b> |    |  |    | <b>126</b> | <b>0</b> |  |    |    |    |

TABLE 5: NTD mapping status

\*NM- Not Mapped

\*NA- Not Applicable

\*Dracunculiasis- Eradicated

\* Borno – Schistosomiasis and Soil Transmitted Helminthiasis have not been mapped in Mobbar LGA while mapping gap of 10 LGAs is still existing for Trachoma

| Endemic NTD                    | Total # Districts | No. of endemic districts | No. of districts mapped or known endemicity status | No. of districts remaining to be mapped or assessed for endemicity status |
|--------------------------------|-------------------|--------------------------|--|---|
| Schistosomiasis                | 774               | 583                      | 773  | 1   |
| Soil Transmitted Helminthiasis | 774               | 429                      | 773  | 1   |
| Onchocerciasis                 | 774               | 480                      | 774  | 143   |
| Lymphatic Filariasis           | 774               | 583                      | 774  | 0   |
| Trachoma                       | 774               | 126                      | 453  | 10  |
| HAT                            | 774               | Unknown                  | 0  | 774   |
| Leishmaniasis                  | 774               | Unknown                  | 0  | 774   |
| Leprosy                        | 774               |                          |  |   |
| Buruli Ulcer                   | 774               |                          |  |   |
| Yaws                           | 774               | Unknown                  | 0  | 774   |
| Dracunculiasis                 | 774               | NA                       | NA   | NA  |
| Snakebite envenoming           | 774               | NA                       | NA   | NA  |
| Rabies                         | 774               | NA                       | NA   | NA  |

Based on information reflected above all the PC-NTDs have been mapped except in Borno. However, there is the need to properly determine the status of leishmaniasis, buruli ulcer, yaws, snakebites, Rabies, and HAT in the country.

TABLE 6: NTD mapping status

## 1.3.2 Performance of other programmes that are closely related to NTD programme

### 1.3.2.1 WASH: WASH and NTD

Water, sanitation, and hygiene (WASH) infrastructure and practices can play a crucial role in the prevention, treatment, care, and management of disability for all 20 neglected tropical diseases (NTDs) prioritized by the World Health Organization (WHO) in its 2021-2030 NTD Road Map.

WASH is essential for preventing NTDs such as trachoma, Guinea worm disease, schistosomiasis, and soil-transmitted helminth diseases (STH).

The overall status of the WASH Sector in Nigeria is low. Only 10% of the population have access to complete basic water, sanitation, and hygiene services, using the global JMP definitions. Those living in rural areas are three times more disadvantaged than those in urban areas. (WASHNORM, 2021)

There is need to invest in WASH structures at the LGA to create the necessary impact of WASH on NTD

Efforts are made to explore the possibility of integrating NTD WASH indicator to the Water, Sanitation and Hygiene Information Management System (WASHIMS) domiciled in Ministry of water resources.

### 1.3.2.2 Mental Health

According to the World Health Organization, NTDs contribute to nearly 1% of the global burden of disease. In fact, more than 1.7 billion people globally require treatment for at least one NTD every year. An estimated 100 million Nigerians are at risk of at least one NTD.

Global and national implementation of NTD programmes, which have largely been preventive and curative, focusing on addressing physical symptoms through mass administration of medicines for more than a decade, has brought some of these NTDs close to elimination. Despite this, very little attention has been paid to morbidity management and the prevention of disabilities due to NTDs. Development actors have paid little attention to the emotional impact of the conditions on affected people, limiting early detection of diagnosable mental health conditions associated with NTDs and providing a proper response to these needs.

Over the last decade, though, there has been improved understanding of the links between mental health, stigma, and NTDs and increased research in this area.

There are many common risk factors for mental health conditions and NTDs, such as poverty, being part of excluded groups, and having poor access to health care and education, implying a high risk of comorbidity. Most people with NTDs experience significant distress and social exclusion, which has an impact on their participation in society, including their civil and political rights<sup>4</sup> and livelihoods—all of

which are recognised determinants of mental illness. The resulting emotional consequences of living with an NTD can lead to psychiatric comorbidities like depression and anxiety, substance abuse, and suicide, exacerbating the physical effects of the conditions. Prevalence estimates of the comorbidity of mental disorders and NTDs vary widely due to weak epidemiological studies but range from 20–90%, and a study in Nigeria found a prevalence of depression among people with LF of 20%.

Already, there is a huge (85%) treatment gap for severe mental disorders in Nigeria because of inaccessible quality mental health services, with treatment restricted to tertiary health institutions and specialist hospitals often located in urban centres; a dearth of mental health professionals in the country (less than 300 psychiatrists for over 200 million people); and poor financing (10% of the federal government's mental health budget) for mental health services.<sup>6</sup> These pose serious challenges to addressing the mental health needs of the growing population arising from other public health priorities (like NTDs, COVID-19, etc.).

Common approaches and platforms for care are a logical solution to this increased risk of comorbidity and neglect of care, including through research in Nigeria. This is now being recognised by a wide range of implementing and donor actors, but there remains a gap in accessible technical support to enable the practical integration of relevant, evidence-based interventions in the field. Also, the roadmap includes a focus on the new Essential Care Package for mental health and stigma in 2023 and will provide practical guidance for service planners and implementers.

The WHO NTD Roadmap, 2021–2030, lays out a progressive agenda, promoting a paradigm shift towards greater national leadership in elimination efforts with impacts based on local priorities and integrated approaches that are more likely to result in a more person-centred approach to care and support. These changes provide an excellent policy framework for better addressing mental health problems associated with NTDs and fertile ground for research that can lead to concrete intervention models for meeting the broader range of needs of people with NTDs. Also, the roadmap includes a focus on the "essential care package," one of which includes mental health and wellbeing. The WHO published a foundational guide, "Mental health of persons with NTDs: Toward a person-centred approach," in 2021. With the existence of evidence-based interventions that are aligned to the SDGs, the Convention on the Rights of Persons with Disabilities (CRPD), and the NNN BEST framework, an integrated MNS (mental, neurological, and substance use) mental health, wellbeing, and NTD response offers opportunities for coordination of national and subnational interventions that will catalyse country efforts towards attainment of the NTD national and global targets. The establishment of the FMOH's National Mental Health Programme offers significant potential for effective collaboration and coordination with the National NTD programme toward this end.

### **1.3.2.3 Disability inclusion**

Apart from the physical impairments that NTDs cause in affected persons, they are also responsible for other consequences such as stigmatization, social exclusion, discrimination, and disability. Most of the 17 main NTDs can lead directly to impairments: trachoma and onchocerciasis can cause blindness, while leprosy, chikungunya, yaws, lymphatic filariasis, Buruli ulcer, Chagas disease, and African trypanosomiasis can lead to physical impairments. NTDs can also cause impairments indirectly. Soil-transmitted

helminths and schistosomiasis in childhood can lead to delayed physical and mental development and a predisposition to developmental disabilities. NTDs are also linked to mental health conditions, particularly depression, whether through the direct effects of disease (e.g., neurological sequelae) or because of the pain, discomfort, and stigma experienced.

Both people with NTDs and people with disabilities experience a myriad of overlapping negative health, financial, and socio-cultural consequences. Disability is particularly prevalent in poor countries and poor communities, which is also where NTDs are concentrated. It is estimated that there are more than one billion people with disabilities worldwide, with at least 80% of them living in developing countries. Most often, people with disabilities face a range of barriers to accessing NTD programmes (e.g., physical inaccessibility, lack of money, and stigma), which is a violation of their rights as set out in the UNCRPD.

Currently, integration of rehabilitation within NTD programmes globally and in Nigeria is lacking for several reasons. The focus on NTD programmes is mostly to prevent and treat, in the belief that if these are effective, then rehabilitation will not be needed. However, not all cases of NTDs can be avoided, and many people are already disabled as a result of NTDs. Another constraint is that disability and morbidity have not been measured routinely in NTD programmes. The lack of data hampers advocacy, planning for interventions, monitoring and evaluating the impact of programmes, and identifying funding. It is thus imperative that national efforts are geared towards changing this trajectory to recognise the importance of disability and make plans to expand the focus on rehabilitation as part of NTD programmes.

The opportunities and need to scale up, integrate, and invest in inclusive, health system-focused NTD programming to the benefit of those at this neglected intersection and beyond should be made a priority towards the realisation of national and global targets for the control and elimination of NTDs, as well as the targets for the SDGs and UHC, as they all rely on ensuring that people with disabilities are not left behind. <sup>11</sup> Making programmes disability inclusive is not difficult, but it does necessitate planning, funding, and collaboration with organisations of people with disabilities and non-governmental organisations focused on disability. This can bring about further benefits for people with NTDs and disabled people at risk of NTDs.

#### **1.3.2.4 Pharmacovigilance**

**Pharmacovigilance:** The science and actions pertaining to the detection, evaluation, comprehension, and prevention of adverse effects or other possible drug-related issues. Pharmacovigilance is a component of patient care that strives to optimize the use of medicines for the treatment or prevention of disease. Good pharmacovigilance detects dangers and risk factors as quickly as feasible in order to prevent or reduce harm.

Pharmacovigilance activities in Nigeria are coordinated by the National Pharmacovigilance Centre (NPC) situated in the National Agency for Food and Drug Administration and Control (NAFDAC—the drug regulatory agency in Nigeria)

NPC serves as a repository for reported adverse drug reactions from health workers and also liaises with other international groups such as the WHO, US Food and Drug Administration and the European Medicines Agency in improving drug safety in Nigeria. Increasing participation of the public in drug safety is also a major thrust of the NPC and the contributions of public-health programmes in this resource-poor setting to pharmacovigilance cannot be overemphasized. The provisions of a unique policy to define the responsibilities of the stakeholders in pharmacovigilance, as well as training of the health-care workers, are a few of the achievements of the agency in charge of pharmacovigilance in Nigeria.

### 1.3.2.5 One Health

One Health is a collaborative, multi-sectoral, and transdisciplinary approach — working at the local, regional, national, and global levels — with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment.

There are exciting opportunities in building system-wide capability and collaboration across stakeholders and sectors, One Health approaches can help to strengthen health systems, reduce duplication and deliver sustainable, cost-effective results. Cross-cutting approaches are advocated in the road map, which sets ambitious global targets to reduce the burden of NTDs in line with United Nations Sustainable Development Goal 3 “to end the epidemics ... of neglected tropical diseases” by 2030. Integrating new strategic and methodological approaches to Nigeria has launched a national one-health strategic plan that integrates human, animal, and environmental health management for improved health security. The plan, which was produced jointly by the Federal Ministries of Health, Agriculture and Rural Development (FMARD), and Environment, as well as their respective agencies, reaffirms Nigeria's commitment to improving multisectoral collaboration for health security. This plan will be implemented over a period of five years. (2018–2023) incorporates NTDs like Rabies

Table 7 Summary of intervention information on existing preventive chemotherapy programmes (as at 2020)

| NTD        | Date programme started | Total No. of LGAs targeted | No. of LGAs covered *(Geographic coverage) | Total population in target LGAs | No. of (percentage) Population Covered | No. of LGAs with require number of effective treatments round | No. of LGAs that have stopped MDA | Key strategies used   | Key partners   |
|------------|------------------------|----------------------------|--|---------------------------------|--|---|-----------------------------------|---|--|
| <b>SCH</b> | 2009                   | 583                        | 583 (30%)                                  | 30,700,443                      | 24,118,924 (78.5%)                     | 0   | 0                                 | MAM, Health promotion and hygiene education, Provision of portable water and environmental and integrated vector management | WHO, Evidence Action, NGOs, Merck, J&J, SS, TCC, HKI, HANDS, MITOSATH, |

|                      |      |     |               |                 |                         |     |     |   |   |
|----------------------|------|-----|---------------|-----------------|-------------------------|-----|-----|---|---|
| <b>STH</b>           | 2010 | 429 | 200<br>(100%) | 39,866,<br>123  | 19,912,<br>611<br>(50)% | 120 | 0   | MAM<br>Health<br>promotion<br>and<br>hygiene<br>education,<br>Provision<br>of<br>portable<br>water and<br>environm<br>ental and<br>integrated<br>vector<br>managem<br>ent | WHO,<br>NGDOs,HA<br>NDs Merck,<br>J&J, SS,<br>TCC,<br>HKI,HANDS,<br>MITOSATH,<br>AMEN<br>FOUNDATI<br>ON                         |
| <b>Oncho</b>         | 1992 | 480 | 480<br>(100%) | 101,47<br>3,434 | 188372<br>64(19%)       | 423 | 59  | MAM<br>(IVM)  | WHO,UNIC<br>EF, NGDO<br>Coalition in<br>Nigeria, RTI<br>Envision,<br>TCC,HKI,HA<br>NDs, CBM,<br>MITOSATH,<br>AMEN<br>Foundation |
| <b>Trach<br/>oma</b> | 2010 | 25  | 25<br>(100%)  | 4,691,8<br>28   | 3,976,6<br>98<br>(85%)  | 0   | 103 | MAM   | Sightsavers,<br>HKI,CBM,<br>HANDS   |

Table 8: Summary information on existing case management programmes

| NTD           | Date<br>programe or<br>intervention<br>started | Total<br>No. of<br>LGAs<br>targeted | No. of LGAs<br>covered<br>*(Geographic<br>coverage) | Key strategies used   | Key partners  |
|---------------|--|-------------------------------------|---|---|---|
| HAT           | 2006   | 200                                 | 21 (10%)  | Active case detection<br>and facility<br>management   | WHO, FIND, AU-<br>PATTEC, NITR,<br>Federal Ministry of<br>Science |
| Guinea worm   | 1988   | 774                                 | 774 (100%)  | Surveillance  | WHO   |
| Rabies        | 1988   | 774                                 | 0   | Active case detection<br>and facility<br>management<br>Administration of H -<br>ARV and HR-AG         | WHO   |
| Leishmaniasis | Not started                                    | 774                                 | 30  | Active case detection<br>and facility<br>management<br>Administration of<br>topicals and<br>infusions | WHO   |

|                       |      |     |           |   |                             |
|-----------------------|------|-----|-----------|---|-----------------------------|
| Leprosy               | 1989 | 250 | 150 (60%) | Active case detection and facility management | ILEP, WHO, ALM              |
| Buruli Ulcer          | 2008 | 60  | 5 (8%)    | Active case detection and facility management | ILEP, WHO, ALM, TLMN, GLRA, |
| Yaws                  | 2017 | 74  | 2         |   | WHO, MITOSATH, GLRA         |
| Rabies                | 2007 | 74  | 12        |   | WHO                         |
| Snakebite Envenominmg | 2000 | 74  |           |   | WHO, Amen Foundation        |

\*Geographical Coverage = No. of LGAs covered by the programme /Total No. of endemic LGAs in the country

### 1.3.3 SWOT Analysis

Table 9: The SWOT Analysis

| STRENGTHS   | WEAKNESSES  | OPPORTUNITIES   | THREATS   |
|---|---|---|---|
| <b>Planning and Coordination</b>  |   |   |   |
| Established focal NTD points in all States except Bayelsa State   | State technical advisory committee in most States (The State NTD Task Force) are not functional | Availability of a newly endorsed National Health Act that can support NTDs programme                | Frequent transfer of NTD staff  |
| Presence of a strong NTD advisory body – The NTD Steering Committee   | Continued vertical programme planning and intervention at the State and National levels         | Presence of a strong legislative arm of government to make policies in favour of the NTDs programme | Bureaucratic bottle necks that slow planning and implementation processes |
| Availability of revised national multi-year strategic plan, NTD policy and disease-specific guidelines          |   |   | Conflicting priority by government at the detriment of NTDs programme     |
| Sustained coordination meetings at national and state level   |   |   |   |
| Involvement of relevant line ministries in annual review and stakeholders meetings                              |   |   |   |
| Availability of clear strategies, protocols, and guidelines for successful programme delivery                   |   |   |   |
| Availability of various integrated NTDs teams at the national level to carry out specific programme assignments |   |   |   |

| <b>Advocacy and Communication</b>  |  |   |  |
|--|--|---|--|
| The current use of media messages for promotion of some NTDs elimination and eradication   | Lack of advocacy champions for integrated NTDs programme in Nigeria                  | Availability of experienced past leaders that can serve as NTD champions  | Poor communication network in rural communities                          |
| Availability of advocacy personnel (zonal coordinators and national program managers) and tools to solicit for required financial and administrative support | Lack of comprehensive integrated NTDs advocacy kits and other IEC materials          |   | Apathy of the public towards the NTD programme                           |
| Routine advocacy visits conducted by zonal coordinators and national programme managers  | Inadequate media publicity of some NTDs  |   |  |
| Availability of a resource mobilization team at the national level to develop NTD resource mobilization guide  | Weak resource mobilization team at the national level to perform its duties          |   |  |
| <b>Scale-up interventions for PCT and Service Delivery Capacity</b>  |  |   |  |
| PCT NTDs mapping conducted in more than 80% of LGAs  | Non-completion of PCT NTDs mapping in a few LGAs in the country                      | Presence of community-based organizations (CBOs) in many communities and LGAs   | Frequent transfer of NTD staff at State and LGA levels                   |
| Availability of donated drugs for NTDs   | Lack of adequate support staff in Zonal offices                                      | Presence of other community-based health programmes with huge financial support in communities                          | Inadequate number of health workers and staff at the LGA and State level |
| The presence of CDI structures in majority of the LGAs for scale-up interventions  | Inadequate number of staff in some NTD programmes at State level                     | Increasing global commitment for NTDs elimination and eradication goals by 2020   | High attrition of community implementers                                 |
| Presence of Community Implementers in majority of communities  | Non retrieval of left over PCT drugs at the community, health facility and LGA level | Presence of strong security organizations such as JTF, local vigilante groups and international agencies like Red cross | Misconception and negative rumors about the NTD programme                |
| Availability of trained Health workers in most Health Facilities and LGAs  | PC drug wastage in some communities/LGAs   | Availability of physical structures that serve as health facilities across the country                                  | Severe Adverse Events from MAM   |
| Availability of trained NTD teams at the State level   | Late commencement of interventions activities due to late arrival of some PC drugs   |   | Security challenges in some parts of the country                         |
| Availability of integrated PC NTD training manuals at all levels of implementation   | Low commitment of health workers and community implementers                          |   | Natural disasters  |
| Annual training and retraining of NTD personnel  | Diminishing community support in many communities endemic for NTDs                   |   |  |

|  |  |  |  |
|--|--|--|--|
|  | Poor preparedness of health facilities and communities (including schools) on the management of SAEs   |  |  |
|  | Poor treatment coverage rates for MAM in urban treatments  |  |  |
|  | <p>Inadequate number of trained school teachers and community implementers for increased programme coverage</p> <p>Lack of personnel at the community and health facility levels for CM-NTDs not disease specific</p> <p>Lack of integrated training materials.</p> <p>Data is not integrated into the NHIS.</p> <p>Lack of integrated case management health facility registers.</p> <p>Lack of visibility at all levels for CM-NTDs.</p> <p>Lack of incentives for active case detection</p> <p>CM-NTDs is not integrated into existing NTD Taskforce.</p> <p>Mapping of all CM-NTDs</p> <p>Limited capacity for the diagnosis and management of CM -NTDs at the health facility level</p> <p>Lack of integrated national guidelines</p> <p>Poor political commitment</p> <p>No integrated workplan</p> <p>Low knowledge and awareness on CM-NTDs at all levels including community stakeholders</p> |  |  |

|  |   |  |  |
|--|---|--|--|
|  | <p>Inadequate number of trained school teachers and community implementers for increased programme coverage</p> <p>Lack of personnel at the community and health facility levels for CM -NTDs not disease specific</p> <p>Lack of integrated training materials.</p> <p>Data is not integrated into the NHIS.</p> <p>Lack of integrated case management health facility registers.</p> <p>Lack of visibility at all levels for CM-NTDs.<br/>Lack of incentives for active case detection</p> <p>CM-NTDs is not integrated into existing NTD Taskforce.</p> <p>Mapping of all CM-NTDs</p> <p>Limited capacity for the diagnosis and management of CM-NTDs at the health facility level</p> <p>Lack of integrated national guidelines</p> <p>Poor political commitment</p> <p>No integrated workplan</p> <p>Low knowledge and awareness on CM-NTDs at all levels including community stakeholders</p> <p>(CM-NTDs) are not included in the Primary Health Care Training packages</p> <p>Poor referral system for CM-NTDs</p> <p>No vehicles for conducting CM-NTDs activities</p> |  |  |
|--|---|--|--|

|  |  |  |  |
|--|--|--|--|
|  | <p>Lack of support for Monitoring and evaluation and supervision activities for CM-NTDs</p>  |  |  |
|  | <p>Poor integration between NTDs and mental health</p> <p>No indicators to capture mental health issues for NTD patients</p> <p>Inadequate cold-chain facilities at state level for Rabies and other CM-NTDs</p> <p>Frequent stock out of drugs due to challenges with the port</p> <p>Inadequate funding for CM-NTDs</p> <p>Poor integration of trichiasis management into eye health systems</p> <p>Poor active surveillance</p> <p>Impact assessment have not been conducted in most states</p> <p>Lack of support for integrated planning</p> <p>Availability of WASH data</p> <p>Low compliance with MAM treatment protocols</p> <p>No Vector control activities instituted</p> |  |  |
|  | <p>Inadequate human resources at the lower levels</p> <p>No standardized recruitment procedure for CDDs and other community volunteers</p> <p>Late remuneration for community implementers</p> <p>Poor information management</p> <p>Poor communication approach from implementers to community members</p> <p>Weak advocacy with policy makers</p> <p>Poor sharing of information and data among agencies</p> <p>Insufficient supply of medicines</p> <p>Non-availability of guidance for setting up sentinel sites</p>   |  |  |

|   |   |  |   |
|---|---|--|---|
|   | <p>Poor data quality from community implementers</p> <p>Delay in clearing of medicines at the ports</p> <p>Inadequate CDDs per population</p>   |  |   |
|   | <p>Low implementation of the SOPs at sub-national levels</p> <p>The absence of an eLMIS database system</p> <p>Lack of storage facilities at the LGA</p> <p>Poor LMIS reporting rate</p> <p>Poor reporting and documentation of reverse logistics.</p> <p>Absence of LMIS reporting tools at the sub-national level</p> <p>There are no defined routine reporting timelines</p> <p>The existing SOP is not explicit and did not provide information on AEs management</p> <p>There no quality assurance measures for medicine in place.</p> |  |   |
| <b>Case Management of NTDs</b>  |   |  |   |
| Existence of NTD structure with a focal person at the national and state levels | Lack of baseline data on most case management diseases  | <p>Vibrant private sector that can be engaged to mobilize resources.</p> <p>Availability of national guideline and framework for management of CM-NTD.</p> <p>Availability of workplan for CM NTD to facilitate programme coordination</p> | Competition for scarce government resources for performance |

|  |  |  |   |
|--|--|--|---|
| <p>Mapping conducted for some CM-NTDs (Leprosy, LF, Trichiasis and BU)</p>             | <p>CM-NTDs are not included in the Primary Health Care Training packages</p> <p>Poor referral system for CM-NTDs</p> <p>Lack of project vehicles for conducting CM-NTDs activities</p> <p>Lack of support for Monitoring and evaluation and supervision activities for CM-NTDs</p> <p>Poor integration between NTDs and mental health</p> <p>No indicators to capture mental health issues for NTD patients.</p> <p>Inadequate cold-chain facilities at state level for Rabies and other CM-NTDs</p> |  | <p>Donor fatigue as partners reduce funding.</p> <p>Inflation leading to high cost of implementation.</p> <p>Recrudescence of Trachoma disease after elimination</p> <p>Inaccessible communities due to violence, flooding and road conditions</p> <p>Cultural/religions norms that could be barriers to change—misconceptions.</p> <p>Bureaucratic bottle necks that slow down planning and implementation processes</p> <p>Donor restriction for funding which affects integration.</p> |
| <p>Existence of technical advisory committee for NTDs exists at the national level</p> | <p>Inadequate knowledge and awareness of case management programmes</p>  |  |   |
|  | <p>Limited capacity for the diagnosis and management of CM-NTDs at the health facility</p>   |  |   |
| <b>Support, Financing and partnerships</b>   |  |  |   |
| <p>Strong collaboration and partnership with NGDOs</p>                                 | <p>Inadequate government commitment to release of counterpart funds</p>  | <p>Increasing global commitment for NTDs elimination and eradication goals by 2030</p> | <p>Competing government priorities</p>  |
| <p>Presence of a strong and closely knit NGDO coalition group for NTDs in Nigeria</p>  |  | <p>Renew commitment to support NTD Elimination through Kigali declaration</p>          | <p>Old donors fatigue</p>   |

|  |  |  |   |
|--|--|--|---|
| Availability of NTDs programme budget line at the national level and some States       | Weak involvement of line ministries in NTD activities. Inadequate inter-sectoral collaboration with line ministries and agencies | Availability of a community based unit under the department of public health in the FMOH     | Bureaucratic bottlenecks to delay progress in planning and implementation     |
| Establishment of some collaboration between the NTDs and Malaria programme             | Lack of a NTD resource mobilization guide  | Interest of new partners in the NTDs programme   | Over-dependence on donor support  |
| Some collaboration with line ministries and agencies e.g Education and WASH            | Lack of cross - border collaboration with other NTDs-endemic countries bordering Nigeria   | Availability of multi-national organization funding for Health Sector like HIV, TB & Malaria |   |
| Partners continuous financial and technical support                                    |  | Transitioning government with new and improved agenda  |   |
| Government support to the provision of human resources for NTDs and their remuneration |  | Presence of JTF, local vigilante groups and international agencies like Red cross            |   |
| <b>Data Management, Monitoring and Evaluation, Operational research</b>                |  |  |   |
| Availability of integrated reporting MIS tools and guidelines                          | Inadequate knowledge of the data collection tools at sub-national levels   | Creation of M -Health for data management  | Loss of historical data through major events                                  |
| Established integrated NTDs data management system                                     | Poor monitoring and supervision due to inadequate funds and logistics  | Interest of partners to build a strong monitoring and evaluation system for NTDs programme   | Insecurity from communal clashes during monitoring and supervisory activities |
| HMIS, IDSR and NDHS captures some NTDs indicators                                      | Inadequate number of operational vehicles  | Existing in-country NTD experts on NTDs monitoring and evaluation                            |   |
| Availability of tools of planning and costing programme activities (TIPAC)             | Numerous health programme forms to be completed by the health worker at the health facility level                                |  |   |
| Availability of integrated forms for case search of case management diseases           | Weak capacity of staff on monitoring and supervision at State and LGA levels   |  |   |
| Existing community monitoring structures for some programmes                           | Late submission of treatment reports from community to the State level   |  |   |
| Conduct of evaluations for some project to determine their elimination status          | Inconsistent data reporting and poor drug inventory  |  |   |

|  |   |  |  |
|--|---|--|--|
|  | Non availability of State based integrated NTD data management system and trained personnel |  |  |
|  | Inadequate capacity for utilization of TIPAC at sub-national levels.                        |  |  |
|  | Absence of functional community based surveillance system                                   |  |  |
|  | Non conduct of regular operational researches to address programme challenges               |  |  |
|  | Cessation of evaluation activities of some projects due to lack of funds to conduct them    |  |  |

### 1.5.1. Gaps and priorities

Based on the SWOT analysis, the major gaps and priorities are itemised (Table 8). Addressing these gaps and focusing on the priorities highlighted will enable Nigeria to achieve its strategic goals as reflected in this plan and eliminate the transmission of some targeted NTDS.

| Gaps   | Priorities  |
|--|---|
| <p><b>Service Delivery</b></p> <p>Limited capacity for the diagnosis and management of CM-NTDs at the health facility level</p> <p>Limited capacity for active case detection at the community level</p> <p>Weak integration of mental health services with NTDS</p> <p>Inadequate laboratory capacity for NTDS</p> <p>Weak collaboration with WASH partners</p> <p>Weak vector control</p> <p>poor referral system for CM -NTDs</p> | <p>Integrate CM_NTDS into pre-service and in-service training</p> <p>Integrate active surveillance for NTDS into the national community health system.</p> <p>Integrate mental health services with NTDS.</p> <p>Increase NTD laboratory capacity and network.</p> <p>strengthen intersectoral collaboration</p> <p>Integrated vector management control</p> <p>Improve the community referral system</p> |
| <p><b>Health Information</b></p> <p>Limited research (including operational research) on NTD interventions</p> <p>The burden of CM-NTDs is not well established; there is an urgent need for mapping and surveillance.</p> <p>Lack of integrated IEC material for CM-NTDs</p> <p>Weak data management system for CM-NTDs</p>   | <p>Resource mobilisation for research</p> <p>Integrated mapping</p> <p>Strengthen integration for awareness and sensitization at all levels.</p> <p>Integrate all NTDS data into the NHIS</p>   |

|  |  |
|--|--|
| Lack of visibility at all levels for CM-NTDs                                       | Increase advocacy with policymakers, the private sector, and community leaders |
| <b>Health Workforce</b>  |  |
| Lack of integrated training for CM-NTDs at all levels                              | Integrated CM-NTDs training  |
| Technical advisory committees not in existence or weak in many States              | Revamp TAG at state level  |
| Limited laboratory capacity for NTDs   | Strengthen laboratory capacity for PCR and other NTDs testing.                 |
| Inadequate human resources at the lower levels                                     | Advocate with state and local levels to designate NTDs personnel               |
| Lack of standardized recruitment procedure for CDDs and other community volunteers |  |
| <b>Leadership and Governance</b>   |  |
| Lack of support for integrated planning  | Strengthen collaborations between line ministries for planning                 |
| Lack of support for Monitoring and evaluation and supervision activities           | Resource mobilization to conduct M&E and supervision activities                |
| <b>Medical Products/supply chain</b>   |  |
| Frequent stock out of drugs due to challenges with the port                        | Collaborate with NAFDAC and relevant agencies                                  |
| Insufficient supply of medicines   | Conduct advocacy with partners to provide medicines                            |
| The absence of an eLMIS database system  | Integrate NTDs into the national eLMIS   |
| <b>Health Financing</b>  |  |
| Inadequate funding for NTDs at the national and country level                      | Strengthen resource mobilisation for programme implementation.                 |
| Inadequate government funding  | Advocate with FMOH to increase funding for NTDs in the national health budget. |
| reduction in partner funding   | Develop proposals for funding  |
| <b><u>Coordination and management</u></b>  |  |
| <u>Inadequate coordination of the multi sectoral NTD implementers</u>              | <u>Strengthen programme coordination</u>                                       |

• PART TWO: NTD STRATEGIC AGENDA •

**2.1. MISSION AND GOALS:**

The Nigeria NTD Master Plan is a five-year plan (2023-2027), that includes Mission, Vision, Guiding principles, Programme Strategic Pillars, and priorities.

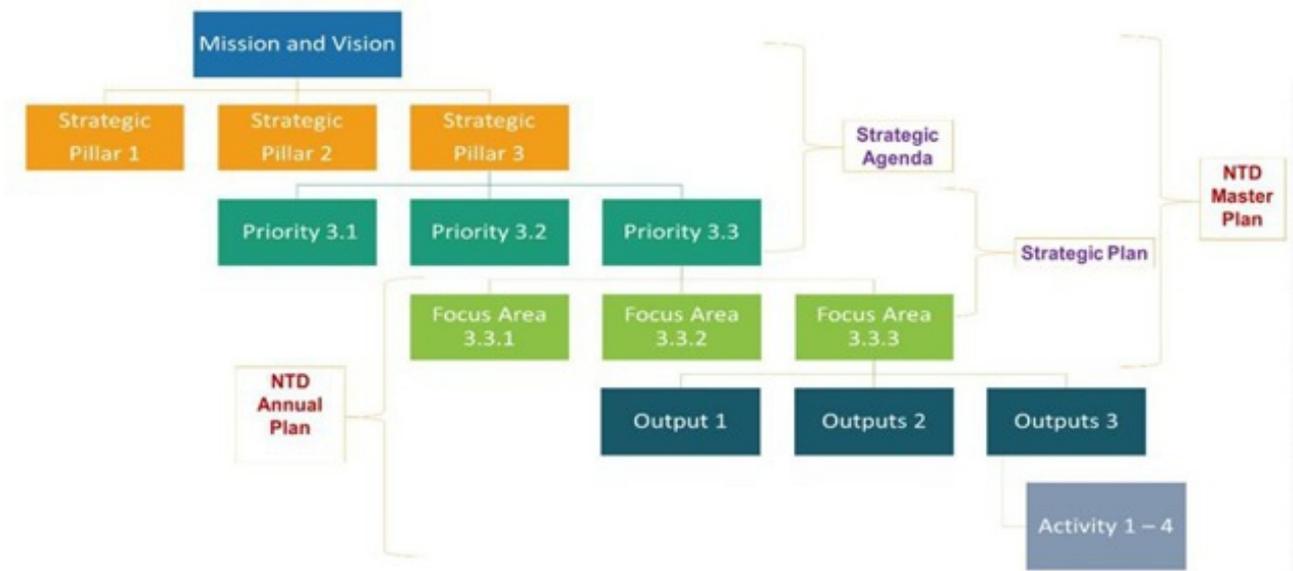


Figure 10. Hierarchy of Objectives for Nigeria NTD programmes

**Section 2.1: NTD Program Mission and Vision**

| Table 9. Mission and vision |   |
|-----------------------------|---|
| <b>Mission</b>              | To eliminate NTDs as a public health problem in Nigeria |
| <b>Vision</b>               | A Nigeria free of Neglected Tropical Diseases           |

2.2.1.1 Overarching Targets

- By 2030 in Nigeria, achieve the:
- The number of people requiring NTD interventions has been reduced by approximately 90%.
  - 774 LGAs have eliminated at least one NTD.
  - Achieve the eradication of yaws and maintain the eradication of Guinea worm disease.
  - Reduce by 90% the number of people requiring treatment for NTDs.
  - At least 21 states must have eliminated onchocerciasis.
  - eradicate two diseases (trachoma and lymphatic filariasis).
  - Reduce the disability-adjusted life years (DALYs) associated with NTD by 75%.

- Disease-specific targets that include a reduction of more than 75% in the number of deaths from vector-borne NTDS
- In places where NTDS are common, make sure everyone has full access to basic water, sanitation, and hygiene.
- Achieve greater improvement in collecting and reporting NTD data disaggregated by gender.
- About 75% of PHCs have staff trained in Mh-GAP implementation guidelines.
- improve the assessment and reporting of mental health co-morbidity in people with NTD.

### 2.2.1.2 Cross Cutting Targets

|                             | <b>Targets</b>   |
|-----------------------------|--|
| Integrated Approaches       | <ul style="list-style-type: none"> <li>• Achieve 75% of the integrated treatment coverage index for preventive chemotherapy (LF, onchocerciasis, SCH, STH, and trachoma).</li> <li>• Adopt and implement integrated skin NTDs strategies in 774 LGAs.</li> <li>• Achieve a 75% reduction in the number of deaths from vector borne NTDS to achieve WHO’s global vector control response goal.</li> <li>• Achieve 100% integration of mental health in the NTD essential care package.</li> </ul> |
| Multisectoral Collaboration | <ul style="list-style-type: none"> <li>• Achieve 100% access to at least basic water supply, sanitation, and hygiene in areas endemic for NTDS.</li> <li>• Establish community support groups for mental health enhancement and stigma reduction activities.</li> </ul>  |
| Country Ownership           | <ul style="list-style-type: none"> <li>• All LGAs are reporting on all relevant endemic NTDS.</li> <li>• All LGAs are reporting gender disaggregated data on relevant endemic NTDS.</li> <li>• All LGAs are reporting on mental health and NTD co-morbid conditions.</li> </ul>  |
| Universal Coverage          | <ul style="list-style-type: none"> <li>• All 36 States and FCT include NTDS in their package of essential services and budgeting</li> <li>• 36 States and FCT use national guidelines for management of NTD-related disabilities within the national health systems</li> <li>• All 36 states and FCT adopt mh-GAP implementation guideline and training of health workers and community members</li> </ul>   |

2.2.1.3 Disease Specific Targets

| NATIONAL TARGET  | DISEASES                                  | OBJECTIVES  | YEAR                       | STRATEGIES                                       |
|--|---|---|----------------------------|--|
| <b>Targeted for elimination (Interruption of Transmission)</b> | Onchocerciasis                            | To achieve 100% geographical coverage and maintain 80% therapeutic coverage in the transmission zones until MAM stops.<br><br>To interrupt transmission and eliminate onchocerciasis in at least 20 states by 2025.<br><br>To reduce, by 2030, transmission of <i>Onchocerca volvulus</i> infection through MAM to the point where the parasite population is irreversibly moving toward its demise in all defined onchocerciasis transmission zones and states in the country. | 2025<br><br>2030           | Mass Administration of Medicines (MAM)           |
|  | Human African Trypanosomiasis (gambiense) | To interrupt the transmission of Human African Trypanosomiasis in Nigeria   | 2027                       | WASH<br>Vector control<br>Case management        |
|  | Leprosy                                   | To ensure early diagnosis and treatment with MDT, elimination of leprosy as a public health problem at national and then elimination at sub-national levels   | 2027                       | WASH<br>Case Management                          |
| <b>Targeted for elimination as a public health diseases.</b>   | Lymphatic Filariasis                      | To eliminate LF as public health problem by 2027  | 2027                       | MAM<br>Case Management                           |
|  | Schistosomiasis                           | Achieve Morbidity control <5% prevalence of heavy intensity in all sentinel sites.<br><br>Transmission control <1% prevalence of heavy intensity in all sentinel sites.   | 2023-2025<br><br>2025-2027 | WASH<br>Vector Control<br>MAM<br>Case Management |

|                |  |   |              |   |
|----------------|--|---|--------------|---|
|                | Soil Transmitted Helminths             | To control disease morbidity of STH eliminate as a public health problem                                      | 2025<br>2027 | MAM<br>WASH<br>Case Management  |
|                | Trachoma                               | Eliminate as Trachoma as a blinding disease   | 2027         | WASH<br>Case Management<br>MAM  |
|                | Rabies                                 | A country free of dog mediated rabies   | 2030         | Case Management<br>Veterinary public health Problem   |
|                | Leishmaniasis (Cutaneous and Visceral) | To eliminate Leishmaniasis as a public health problem   | 2027         | Early and community-based case detection<br>Case management (topical and prevention of disabilities)              |
| <b>Control</b> | Snakebite                              | To ensure patients have overall care, so that the number of deaths and cases of disability are reduced by 50% | 2030         | Case Management   |
|                | Buruli Ulcer                           | To ensure early detection and early treatment for effective control; increasing surveillance and control      | 2030         | Early and community-based case detection<br>Case management (antibiotics, surgery and prevention of disabilities) |

|                    |   |   |             |  |
|--------------------|---|---|-------------|--|
|                    | <u>Mental Health and NTD co-morbid conditions</u>       | To achieve 75% prevention and control of common mental health conditions and suicide by promoting mental health-enhancing therapies and stigma-reducing activities. | <u>2030</u> | <u>Implementation of WHO essential care package for mental health and NTDs</u> |
| <b>Eradication</b> | Guineaworm Disease                                      | To maintain WHO certification as country free of Guineaworm disease   | 2030        | WASH<br>Vector control<br>Passive Surveillance                                 |
|                    | Yaws  | To eradicate Yaws 2030  | 2030        | Case Management<br>MAM   |
| <b>Others</b>      | <b>Noma Disease<br/>Ringworm<br/>Scabies<br/>Eczema</b> | These are the abandon diseases and need to be catered for.  |             |  |

## 2.2.2 MILESTONES

Table 10.1: LF Milestone

|   | <b>Indicators</b>   | <b>2023</b>   | <b>2024</b>    | <b>2025</b>    | <b>2026</b>    | <b>2027</b>    |
|---|---|---------------|----------------|----------------|----------------|----------------|
| 1 | Completed mapping of LF and determined LF endemic areas and the population at risk  | 774<br>(100%) |                |                |                |                |
| 2 | Begun implementation of LF MDA in districts requiring LF MDA  | 558<br>(100%) |                |                |                |                |
| 3 | Achieving 100% geographical coverage in LF endemic districts  | 558<br>(100%) |                |                |                |                |
| 4 | Major urban areas with evidence of LF transmission under adequate MDA (LGA coverage more than 65%)                                      | 371<br>(90%)  | 411<br>(100%)  |                |                |                |
| 5 | Conducted more than 5 rounds of MDA in endemic IUs with LGA coverage more than 65% and stopped MDA in LF endemic IUs under WHO criteria | 94<br>(16%)   | 133<br>(22.7%) | 227<br>(38.7%) | 360<br>(61.3%) | 558<br>(100%)  |
| 6 | Conducted first TAS activities in LF endemic IUs after at least 5 rounds of MDA   | 30<br>(5.1%)  | 99<br>(16.9%)  | 129<br>(22%)   | 228<br>(38.8%) | 357<br>(60.8%) |
| 7 | Conducted and Passed at least 2 TAS activities in IUs   | 29<br>(4.9%)  | 29<br>(4.9%)   | 98<br>(16.7%)  | 127<br>(21.6%) | 225<br>(38.3%) |

|    |   |               |                |                |                |                |
|----|---|---------------|----------------|----------------|----------------|----------------|
| 8  | Started passive surveillance and vector control activities in IUs.  | 29<br>(4.9%)  | 29<br>(4.9%)   | 98<br>(16.7%)  | 127<br>(21.6%) | 225<br>(38.3%) |
| 9  | Proportion and number of IUs where there is full coverage of morbidity management services and access to basic care | 89<br>(11.5%) | 173<br>(22.4%) | 243<br>(31.4%) | 294<br>(38%)   | 480<br>(62%)   |
| 10 | Proportion and number of IUs where 75% of hydrocele cases benefitted from appropriate surgery                       | 78<br>(10%)   | 147<br>(19%)   | 204<br>(26%)   | 294<br>(38%)   | 480<br>(62%)   |

Table 10.2: Oncho Elimination Milestones

|   | Indicators (No. Of States)  | 2023      | 2024      | 2025     | 2026      | 2027      |
|---|---|-----------|-----------|----------|-----------|-----------|
| 1 | Complete mapping in transmission zones with limited information on onchocerciasis (Blue) and begin MAM where necessary              | 4 (50%)   | 8 (100%)  |          |           |           |
| 2 | Achieve 100% geographic and 65% therapeutic coverage in Onchocerciasis endemic LGAs   | 21 (100%) |           |          |           |           |
| 3 | Evaluate and reclassify transmission zones where transmission of onchocerciasis is suspected to be interrupted (Tan)                | 6 (46%)   | 13 (100%) |          |           |           |
| 4 | Evaluate and reclassify transmission zones where transmission of onchocerciasis is suspected to be on track to elimination (Yellow) | 4 (44%)   | 9 (100%)  |          |           |           |
| 5 | Evaluate and reclassify areas where transmission of onchocerciasis is suspected to be ongoing (Red)                                 | 1 (100%)  |           |          |           |           |
| 6 | Pass WHO criteria for stopping MAM (Tan & Yellow)   | 0 (0%)    | 6 (27%)   | 13 (59%) | 22 (100%) |           |
| 7 | Enter post treatment surveillance for transmission zones that have stopped MAM  | 0 (0%)    | 0 (0%)    | 6 (27%)  | 13 (59%)  | 22 (100%) |

Table 10.3: STH Elimination Milestones 2023-2027

|   | INDICATORS  | 2023       | 2024      | 2025      | 2026      | 2027       |
|---|---|------------|-----------|-----------|-----------|------------|
| 1 | Completed mapping of STH and determined areas above intervention threshold and the Endemic population                               | 774 (100%) |           |           |           |            |
| 2 | Begin implementation of school-based/community-based treatments in Endemic LGAs   | 774 (100%) |           |           |           |            |
| 3 | Achieving 100% geographical coverage in STH Endemic LGAs  | 774 (100%) |           |           |           |            |
| 4 | Achieving minimum of 75% Therapeutic coverage in STH endemic LGAs   | 774 (100%) |           |           |           |            |
| 5 | Conducted first mid-term assessment activities in at least 50% of STH Endemic LGAs after at least 3 years of consecutive treatments | 155 (20%)  | 310 (40%) | 464 (60%) | 619 (80%) | 774 (100%) |

|    |   |          |           |           |           |           |
|----|---|----------|-----------|-----------|-----------|-----------|
| 6  | Conducted 5 years of consecutive treatments in all Endemic LGAs with LGA coverage more than 75% | 77 (10%) | 155 (20%) | 310 (40%) | 464 (60%) | 619 (80%) |
| 7  | Endemic LGAs achieving moderate morbidity control (WHO intensity grading)                       | 77 (10%) | 155 (20%) | 310 (40%) | 464 (60%) | 619 (80%) |
| 8  | Endemic LGAs achieving advanced morbidity control (WHO intensity grading)                       | 77 (10%) | 155 (20%) | 310 (40%) | 464 (60%) | 619 (80%) |
| 9  | Proportion of LGAs with Basic WASH  | 77 (10%) | 155 (20%) | 310 (40%) | 464 (60%) | 619 (80%) |
| 10 | Proportion of LGAs achieving Open Defecation Free   | 77 (10%) | 155 (20%) | 310 (40%) | 464 (60%) | 619 (80%) |
| 11 | Endemic LGAs achieving elimination of transmission  | 0(0%)    | 77 (10%)  | 155 (20%) | 310 (40%) | 464 (60%) |

Table 10.4 **Trachoma Milestones 2023-2027**

| INDICATORS  | 2023       | 2024      | 2025      | 2026       | 2027     |
|---|------------|-----------|-----------|------------|----------|
| Completed mapping of trachoma and determined areas above intervention threshold and the target population       | 257 (100%) |           |           |            |          |
| Begun implementation of community -based treatments in target districts   | 51 (72%)   | 53(75)    | 70(100%)  |            |          |
| Achieved 100% geographical coverage in trachoma target districts  | 51 (72%)   | 53(75%)   | 70(100%)  |            |          |
| Conducted 3-5 rounds of treatments in target districts with LGA coverage more than 75%                          | 27 (42%)   | 42 (65%)  | 52 (80%)  | 70 (100%)  |          |
| Conducted first impact assessment activities in trachoma target districts after at least 3 rounds of treatments | 16 (25%)   | 31 (44%)  | 34 (49%)  | 64 (91%)   | 64 (91%) |
| Started passive surveillance in IUs.  |            | 16 (25%)  | 31 (44%)  | 34 (49%)   | 64 (91%) |
| Proportion and number of target districts where there is full coverage of case management services              | 146 (61%)  | 180 (76%) | 197 (83%) | 237 100(%) |          |
| Target LGAs achieved elimination of blinding trachoma   | 16 (25%)   | 31 (44%)  | 34 (49%)  | 64(91%)    | 64(91%)  |

Table 10.5 Schistosomiasis milestone 2023-2027

|    | INDICATORS   | 2023         | 2024        | 2025        | 2026        | 2027         |
|----|--|--------------|-------------|-------------|-------------|--------------|
| 1  | Completed mapping of SCH and determined SCH endemic areas and the population at risk   | 9,684 (100%) |             |             |             |              |
| 2  | Begun implementation of SCH MDA in wards requiring SCH MDA   | 6,363 (100%) |             |             |             |              |
| 3  | Achieving 100% geographical coverage in SCH endemic Wards  | 6,363 (100%) |             |             |             |              |
| 4  | Achieving minimum of 75% Therapeutic coverage in SCH endemic Wards   | 6,363 (100%) |             |             |             |              |
| 5  | Conducted first mid-term assessment activities in Endemic Wards after at least 3 years of consecutive treatments   | 1,273 (20%)  | 2,545 (40%) | 3,818 (60%) | 5,090 (80%) | 6,363 (100%) |
| 6  | Conducted first impact assessment activities in at least 50% of SCH Endemic Wards after at least 5 years of consecutive treatments achieving minimum coverage of 75% | 636 (10%)    | 1,273 (20%) | 2,545 (40%) | 3,818 (60%) | 5,090 (80%)  |
| 7  | Proportion of endemic wards achieving moderate morbidity control (WHO intensity grading)   | 636 (10%)    | 1,273 (20%) | 2,545 (40%) | 3,818 (60%) | 5,090 (80%)  |
| 8  | Proportion of endemic wards achieving advanced morbidity control (WHO intensity grading)   | 636 (10%)    | 1,273 (20%) | 2,545 (40%) | 3,818 (60%) | 5,090 (80%)  |
| 9  | Proportion of wards where application of molluscicide have begun   | 0(0%)        | 636 (10%)   | 1,273 (20%) | 2,545 (40%) | 3,818 (60%)  |
| 10 | Proportion of wards begin snail control  | 636 (10%)    | 1,273 (20%) | 2,545 (40%) | 3,818 (60%) | 5,090 (80%)  |
| 11 | Completed setting up of at least 3 Snail molecular Biology Laboratory  | 1 (30%)      | 2 (60%)     | 3 (100%)    |             |              |
| 12 | Proportion of wards with Basic WASH  | 1200 (20%)   | 3800(60%)   | 4400(70%)   | 5400 (85%)  | 6363(100%)   |
| 13 | Proportion of Wards achieving Open Defecation Free   | 1600(25%)    | 2200(35%)   | 3800(60%)   | 4770(75%)   | 5400(85%)    |
| 14 | Endemic wards achieving elimination of transmission  | 0(0%)        | 0(0%)       | 636 (10%)   | 955 (15%)   | 1,273 (20%)  |

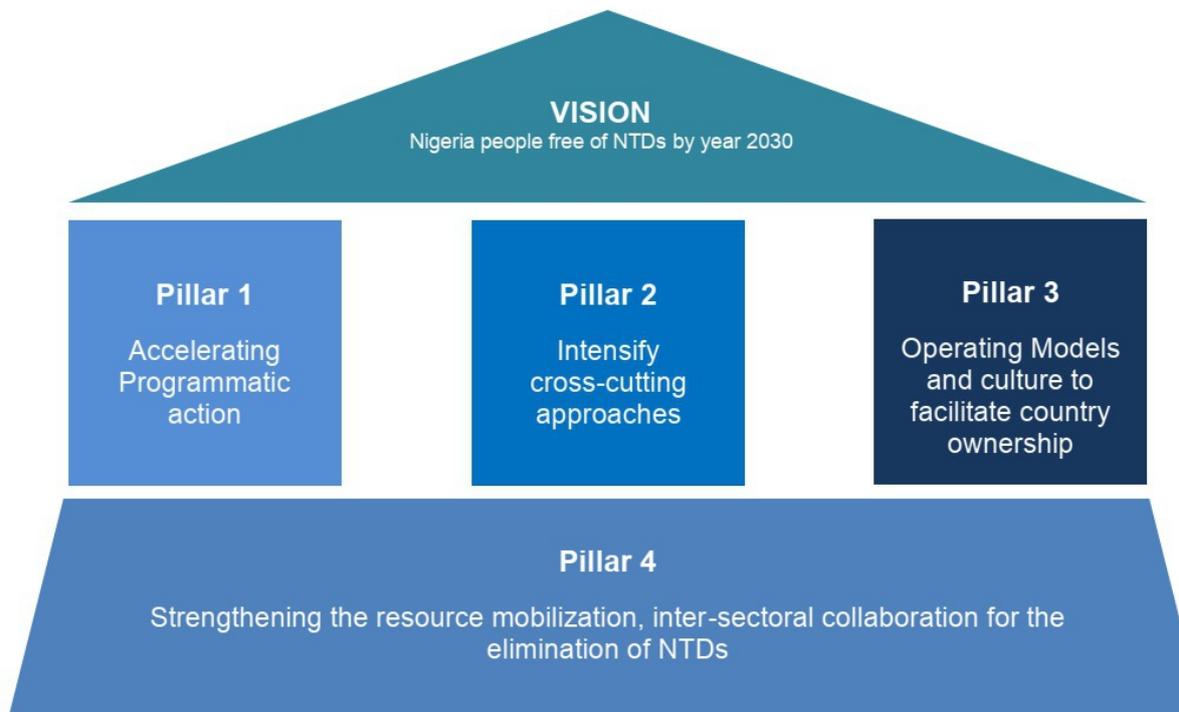
Section 2.3: Guiding Principles

**Table 13. Guiding principles**

|                           |  |
|---------------------------|--|
| <b>Guiding principles</b> | <ul style="list-style-type: none"> <li>• National leadership and ownership,</li> <li>• Commitment to collaboration and sharing,</li> <li>• Mutual accountability of national authorities and partners, Transparency, and accountability,</li> <li>• Community engagement and participation</li> <li>• Safety: 'Do no harm' while providing health benefits</li> <li>• Leave no one behind</li> </ul> |
|---------------------------|--|

**Section 2.4: Strategic Pillars and Strategic Objectives**

**2.4.1. Programme Strategic Pillars**

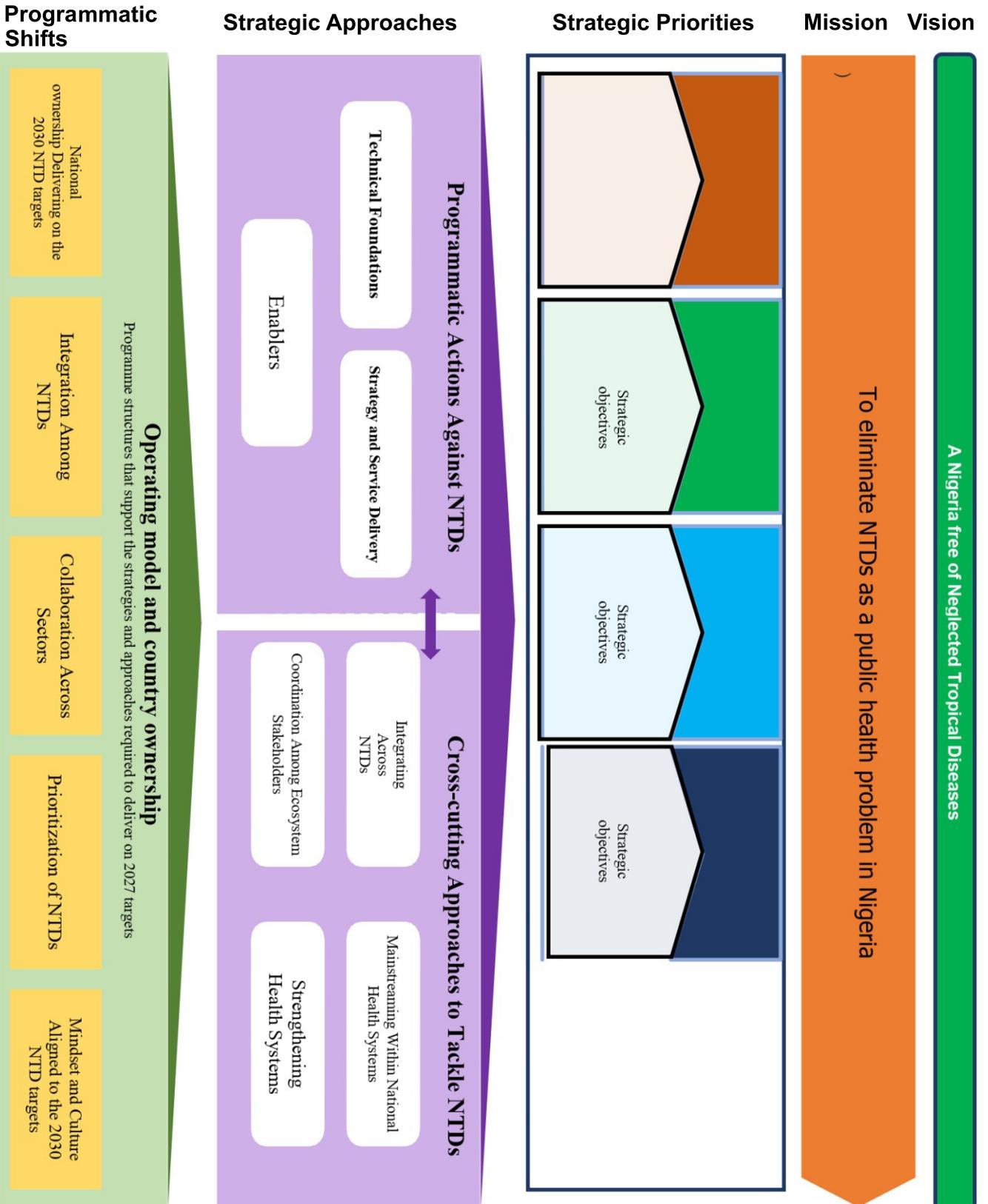


2.4.2. Strategic Priorities

Table 11. Strategic Priorities for the Elimination of Neglected Tropical Diseases

| Strategic Pillar  | Priorities   |
|---|--|
| <p><b>Pillar 1.</b><br/><b>Accelerating programmatic action</b></p>   | <p>1.1 Scale up integrated preventive chemotherapy to achieve 100% geographic coverage and treatment access to lymphatic filariasis, Onchocerciasis, Soil transmitted Helminths, Trachoma and Schistosomiasis</p> <p>1.2 Scale up mapping for case management NTDs diseases (Snakebite Envenoming, Yaws, Rabies and Leishmaniasis) and Human African Trypanosomiasis)</p> <p>1.3 Scale-Up Access to Case management Interventions, Treatment &amp; Service Delivery</p> <p>1.4 Strengthening access to people-centered mental healthcare for people with Skin NTDs in Nigeria.</p> <p>1.5 Prioritize and strengthen monitoring and evaluation to track progress and decision making towards aligned targets.</p> <p>1.6 Strengthen Programme coordination.</p> <p>1.7 Ensure timely, safe, and effective supply chain management of quality assured NTD Medicines and other products up to the last mile</p> |
| <p><b>Pillar 2.</b><br/><b>Intensify cross-cutting approaches</b></p> | <p>2.1 Strengthen identified platforms with similar delivery strategies and interventions (MAM, skin NTDs, Morbidity management, SBCC, WASH etc) for integrated approaches across NTDs</p> <p>2.2 Mainstream CM-NTDs delivery platforms within the national health system</p> <p>2.3 Strengthen cross-sectoral collaboration and ensure coordinated, integrated action in primary health care and in communities</p> <p>2.4 Integrate safety across NTD planning, implementation, and monitoring.</p> <p>2.5 Strengthening access to essential psychotropic medications as well as those for physical needs for skin NTD patients.</p> <p>2.6 Reduce stigma and discrimination related to NTD morbidity.</p> <p>2.7 Strengthen monitoring and evaluation system and integrate relevant NTDs into NHMIS</p>   |

|   |   |
|---|---|
| <p>Pillar 3.<br/>Operating Models and culture to facilitate country ownership</p>                                 | <p>3.1 Improve governance and coordination for implementation of Mental Health and NTD</p> <p>3.2 Promote and strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding.</p> <p>3.3 Promote community inclusion, participation, and ownership of the program for optimal use of available resources.</p> <p>3.4 Strengthen national capacity to sustain implementation of efficient, integrated NTD control programmes with well-trained, supervised health care providers and managers.</p> <p>3.5 Empower local government and authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions.</p>  |
| <p>Pillar 4.<br/>Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs</p> | <p>4.1 Increase political commitment to support NTD intervention.</p> <p>4.2 Improve advocacy to pharmaceutical industry, bilateral and multilateral donors, and private philanthropists.</p> <p>4.3 Strengthen Governance and multi-sectoral coordination with Poverty, WASH, disability management and Education</p> <p>4.4 Promote the incorporation of NTDs into countries' UHC packages, national health plans and global progress reports</p> <p>4.5 Increase NTDs programme visibility among the Country's decision makers and influencer</p> <p>4.6 Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.</p> <p>4.7 Strengthen and foster partnership for CM-NTDs.</p> <p>4.8 Enhance resource mobilization approaches and strategies at all levels.</p> |



**PART THREE:  
IMPLEMENTING THE STRATEGY: NTD OPERATIONAL FRAMEWORK**

In line with the 2021 - 2030 NTD Global Roadmap, this strategic plan is geared towards ensuring three fundamental shifts in the approach to tackling NTDs: first, increase accountability for impact by using impact indicators instead of process indicators, as reflected by the targets and milestones in Part II and accelerate programmatic action; secondly, move away from siloed, disease-specific programmes by mainstreaming programmes into national health systems and intensifying cross-cutting approaches centred on the needs of people and communities: and thirdly, change operating models and culture to facilitate greater ownership of programmes in South Africa.

**Section 3.1: Strategic priorities and Key Activities**

**Strategic Pillar I - Accelerating Programmatic Actions**

Table 11: Strategic Pillar and Activities

| Strategic Priorities   | Activities  | Resources needed  | Timeframe | Action by                   |
|--|---|---|-----------|-----------------------------|
| <b>1.1 Scale up integrated preventive chemotherapy to achieve 100% geographic coverage and treatment access to lymphatic Filariasis and Onchocerciasis, Soil transmitted Helminths, Trachoma and Schistosomiasis</b> | <ol style="list-style-type: none"> <li>1. Integrated Capacity building of implementers at all levels</li> <li>2. Conduct integrated MAM in all endemic LGAs for PC NTDs.</li> <li>3. MAM supervision</li> </ol>   | Human resource, Funding, Logistics & Communication IEC materials.                   | 2023-2027 | LGAs, State, FMOH, Partners |
| <b>1.2 Scale up interventions for case management NTDs (Snakebite Envenoming, Yaws, Rabies and Leishmaniasis), Human African Trypanosomiasis and Mental Health comorbidity)</b>                                      | <ol style="list-style-type: none"> <li>1. Mapping of CM-NTDs in states with reported cases (Snakebite Envenoming in at least 12 states), Rabies in 13 states, Leprosy/BU in 4 states, Yaws 12 states, Leishmaniasis 3 states, HAT in 6 states.</li> <li>2. Mapping of FGS in the 36 States and FCT.</li> <li>3. Capacity Building of health workers and community members for Case Detection of FGS (e.g TBAs).</li> <li>4. Capacity building of non-specialist health workers and community members for mental health assessment and interventions with 2-way referral protocol for specialist cases.</li> </ol> | Human resource, Funding, Medical products, Logistics & Communication IEC materials. | 2023-2025 | LGAs, State, FMOH, Partners |

|   |  |  |                      |   |
|---|--|--|----------------------|---|
| <p><b>1.3 Scale up integrated case management-based disease intervention for Yaw/Leishmaniasis/TBL, FGSand Trichiasis, BU and Leprosy, Snake bite, Envenoming &amp; Rabies.</b></p> | <ol style="list-style-type: none"> <li>1. Develop integrated training manuals for CM-NTDs at all levels</li> <li>2. Conduct integrated training for health workers (at least 2 per HF) on the diagnosis, management and reporting of CM-NTDs</li> <li>3. Develop integrated CM-NTDs health facility registers</li> <li>4. Develop a two-way referral/feedback form from community to health facilities</li> <li>5. Provide support to the primary healthcare system to Integrate CM-NTDs active case finding training/activities into community volunteers or implementers training</li> <li>6. Train laboratory scientists on PCR and other tests for NTDS</li> <li>7. Distribute RDT and DPP tests to health facility for yaws</li> <li>8. Conduct training for community health workers on active case finding and community sensitization</li> <li>9. Conduct contact tracing for all confirmed Yaws and leprosy cases</li> <li>10. Procure medicines and commodities for all CM-NTDs</li> <li>11. Provide home based self-care kits for lymphedema patients</li> <li>12. Integrated CM-NTDs drugs into central medicine store</li> <li>13. Train health workers on managing complications of CM-NTDs that are referred from the primary health facilities</li> <li>14. Follow up post-surgery patients (hydrocele and TT)</li> <li>15. Develop visual aids for community health workers to use during case finding and awareness</li> <li>16. Provide assistive devices and rehabilitation for CM-NTDs patients with disability or morbidity challenges post treatment</li> </ol> | <p>Human resource, Meeting Hall, Funding, Logistics &amp; Communication IEC materials.</p> | <p>2023<br/>2027</p> | <p>Community, LGAs, State, FMOH, Partners</p> |
|---|--|--|----------------------|---|

|   |  |  |                  |   |
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|   | <p>17. Support integrated peer support groups at the community level</p> <p>18. Build the capacity of National NTD Programme Managers on CM-NTDs</p> <p>19. Develop integrated supervision form for CM-NTDs</p> <p>20. Conduct data quality assessment/verification on a quarterly basis</p> <p>21. Integrate supervisory system for CM-NTD into the existing National NTD</p> <p>22. Train traditional healers/herbalists, Church leader, Imams etc. to refer suspected CM-NTDs cases.</p> <p>24. Provide incentives for community members who refer suspected NTD cases that are confirmed</p> | <p>Human resource, Meeting Hall, Funding, Logistics &amp; Communication IEC materials.</p> | <p>2023-2027</p> | <p>Community, LGAs, State, FMOH, Partners</p> |
| <p><b>1.4 Strengthen access to people-centered mental healthcare for people with Skin NTDs and physical deformities in Nigeria.</b></p> | <p>1. Improve access to mental health support and treatment</p> <p>2. Improve access to livelihood opportunities for people affected by Skin NTDs.</p> <p>3. Improve public awareness to reduce stigma on mental health conditions in Skin NTDs and physical deformities.</p> <p>4. Screen all NTDs patients for mental health conditions at diagnosis and while on treatment.</p>   | <p>Human resource, Funding, Logistics &amp; Communication</p>                              | <p>2023-2027</p> | <p>Community, LGAs, State, FMOH, Partners</p> |

|   |  |  |             |                   |
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| 1.5 Prioritize and strengthen monitoring and evaluation to track progress and decision making towards aligned targets | Conduct Epidemiological, Entomological and elimination mapping for onchocerciasis in all relevant transmission zones           | Human resource, Funding, Logistics, Tools,   | 2023-2027   | FMOH and Partners |
|   | Conduct all outstanding Pre-TAS and TAS surveys in relevant implementation units   | Human resource, Funding, Logistics, Tools,   | 2023-2027   |                   |
|   | Conduct trachoma baseline mapping in 10 LGAs of Borno state by 2023  | Human resource, Funding, Logistics, Tools,   | 2023-2027   |                   |
|   | To complete all trachoma impact and surveillance surveys by 2027   | Human resource, Funding, Logistics, Tools,   | 2023-2027   |                   |
|   | Conduct Impact assessment in all Implementation units that have conducted 5 effective round of treatment of Schisto and/or STH | Human resource, Funding, Logistics, Tools,   | 2023-2027   |                   |
|   | Hold meetings to review and finalise the draft impact assessment guidelines for SCH and STH                                    | Human resource, Funding, Logistics, Tools,   | 2023 - 2024 |                   |
|   | Mapping of Female Genital Schistosomiasis (FGS) in the 36 States and FCT   | Human resource, Funding, Logistics, Tools,   | 2023-2027   |                   |
|   |  | resource, Funding, Logistics, Tools,<br><br>Human resource, Funding, Logistics, Tools, |             |                   |

|  |  |   |  |  |
|--|--|---|--|--|
|  | <p>Capacity Building of health workers and community members for Case Detection of FGS (e.g TBAs) in at least 10 PHCs per endemic States</p> <p>Identify/Establish 3 snail intermediate host control Laboratory for vector Identification and management</p> <p>Identify/Establish seven (7) molecular laboratories for sample analysis - one in FCT, Northwest, Northeast, North Central, Southwest, South South and Southeast zones (Acquire lab space, procure consumables and equipment, Certification of labs), for onchocerciasis evaluation survey analysis</p> <p>Establish Partnerships with research institution to accelerate trials of new innovative technologies for rapid diagnosis</p> <p>Laviciding of water bodies within Schistosomiasis endemic communities</p> <p>Establishment of TWG for Monitoring and Evaluation (M&amp;E), ACSM, WASH and LF for dossier preparation</p> | <p>Space, Laboratory equipment, Reagents, Human Resource, Facilitators, Logistics, Communication, 2023 - 2024, FMOH, Partners</p> |  |  |
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|  |   |  |                    |                       |
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|  | <p>Finalization of Post Elimination Surveillance (PES) plans including approved IEC materials, plans for immigrants and Internally displaced persons in view of Onchocerciasis and Lymphatic Filariasis elimination in Plateau and Nasarawa</p> <p>Distribution of PES IEC materials in Plateau and Nasarawa<br/>Conduct post treatment surveillance activities in 19 States (mobilization and sensitization, entomological evaluation, IEC materials, Meetings)</p> <p>Establish structures and commence MAM in Internal Displaced Persons (IDPs) and Refugee camps for treatment of onchocerciasis and Lymphatic Filariasis</p> <p>Meeting to Finalize review of integrated Supervisory checklist for use at all levels</p> | <p>Space, Laboratory equipment, Reagents, Human Resource, Facilitators, Logistics, Communication, Funding, Tools</p> | <p>2023 -2024,</p> | <p>FMOH, Partners</p> |
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|  |   |   |             |               |
|--|---|---|-------------|---------------|
|  | <p>Capacity building on the use of supervisory checklist at all levels.</p> <p>Conduct coverage evaluation surveys in PC NTD endemic areas of 36 States and FCT.</p> <p>Conduct quality standard assessment in 36 States and F.C.T</p> <p>Conduct mid term assessment of NTD Masterplan 2023-2027</p>   | Human resource, Funding, Logistics, Tools,                              | 2023        |               |
| <b>1.6 Strengthen Programme coordination</b> | <ol style="list-style-type: none"> <li>1. Conduct bi-annual TWG meetings for Oncho, LF, Trachoma, Schisto, STH, M&amp;E, WASH, ACSM, MH.</li> <li>2. Collection, collation, review and validation of annual technical reports, treatment and training data for 36 States and FCT.</li> <li>3. Meeting for the completion of Final NTD Annual Technical Report annually.</li> <li>4. Conduct Bi-annual NTD Steering Committee meeting Quarterly NTD Review Meetings (National, Zonal, Validation meetings, Internal Meetings, Meetings with partners).</li> <li>5. Cross Border Collaboration with Cameroon and Benin Republic (Meetings, Monitoring and Supervision).</li> <li>6. Conduct bi-annual national NTFs steering committee meeting</li> </ol> | Human resource, Meeting Hall, Funding, Logistics, Tools, IEC materials. | 2023 - 2027 | FMOH Partners |

|   |   |   |                    |                       |
|---|---|---|--------------------|-----------------------|
| <p><b>1.7 Ensure timely, safe and effective supply chain management of quality assured NTD &amp; psychotropic Medicines and other products up to the last mile.</b></p> | <p>1. Train LGA surveillance officers/NTDs focal persons on surveillance for pharmacovigilance assessments/surveillance of MDA SAEs.</p> <p>2. Strengthen logistic management system of CM-NTDs (Rabies and Snakebite Vaccines and cold chain facilities, Leprosy medicines, FGS)</p> | <p>Human resource, Logistics and communication, Funding, Meeting hall, Tools, IEC materials</p> | <p>2023 - 2027</p> | <p>FMOH, Partners</p> |
|---|---|---|--------------------|-----------------------|

**Part 3: Section 2 (Strategic Pillar 2 - Intensify cross-cutting approaches)**

**Table 17: Intensify Cross-cutting approaches**

|   |   |   |                    |   |
|---|---|---|--------------------|---|
| <p><b>2.1 Strengthen identified platforms with similar delivery strategies and interventions (MDAs, skin NTDs, Morbidity management, SBCC, WASH etc) for integrated approaches across NTDS.</b></p> | <p>1. Development of guideline on use of the WASH-NTD merge.</p> <p>2. Stakeholders Sensitization meeting to integrate schistosomiasis elimination programme into routine services of PHCs especially for the management of Female Genital Schistosomiasis</p> <p>3. Establishment of a WASH-NTD Coordination office: Assign desk officer and supporting staff.</p> <p>4. Equip WASH office</p> <p>5. Capacity Building for WASH-NTD officers</p> <p>6. Collation and update on all WASH-NTD related data</p> <p>7. Hold meeting with WASH agencies and line ministries to merge WASH -NTD data</p> | <p>Logistics and communication, Honorarium, Human resource, Funding, Meeting hall, TWG, Tools, Reference Documents.</p> | <p>2023 - 2027</p> | <p>LGAs, State, FMOH, Partners, TWG</p> |
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|   | <p>8. Advocacy to Water agencies and UNICEF to prioritize communities with high burden of WASH related NTDs in provision of boreholes and toilet facilities.</p> <p>9. Capacity building on the use of WASH-NTD merge at all levels</p> <p>10. Scale up on the use of the WASH-NTD merge platform by all states</p> <p>11. Update and validation of data on the WASH-NTD platform</p> <p>13. Health education, sensitization and mobilization on proper WASH practices in health facilities and schools, with promotion of activities on Improved environmental sanitation and behavioural change communication through the development and distribution of IEC materials</p> <p>14. Liaise with RUWASA to conduct community led total sanitation in all communities by 2027.</p> <p>15. Hold meeting with WASH agencies and line ministries to merge WASH-NTD data and review WASH NTD activities.</p> <p>16. Advocacy to Water agencies and UNICEF to prioritize communities with high burden of WASH related NTDs in provision of boreholes and toilet facilities</p> <p>17. Advocacy to development partners, state, local and community authorities to support training on mh-GAP implementation guidelines.</p> | <p>Logistics and communication, Honorarium, Human resource, Funding, Meeting hall, TWG, Tools, Reference Documents.</p> | <p>2023 - 2027</p> | <p>State, FMOH, Partners, TWG</p> |
| <p><b>Mainstream CM-NTDs delivery platforms within the national health system</b></p> | <p>1. Hold stakeholders meeting to agree on key indicators for CM -NTDs data collection</p> <p>2. Development of integrated CM-NTDs reporting data collection tools</p> <p>3. Development and filed testing of CM-NTDs tools</p>  | <p>Logistics and communication Human resource, Funding, Meeting hall &amp; Tools</p>                                    | <p>2023</p>        | <p>State, FMOH, Partners</p>      |

|   |   |  |                      |  |
|---|---|--|----------------------|--|
| <p><b>Strengthen cross-sectoral/ intersectoral collaboration and ensure coordinated, integrated action in primary health care and in communities- intersectoral collaboration, collaborated with NAFDAC</b></p> | <p>Hold meetings with relevant stakeholders at all level</p>  | <p>Logistics and communication<br/>Human resource,<br/>Funding, Meeting hall</p>                   | <p>2023<br/>2025</p> | <p>FMOH,<br/>Partners</p>                      |
| <p><b>Integrate safety across NTD planning, implementation, and monitoring</b></p>  | <ol style="list-style-type: none"> <li>1. Develop protocol for managing, reporting and investigating adverse events and serious adverse events</li> <li>2. Availability of medicine for managing adverse event and serious adverse event at health facility and to drug distributors</li> <li>3. Communications plan developed and rehearsed in the event of serious adverse events or rumour</li> <li>4. Capacity building of spokesperson on NTDs safety across all level</li> <li>5. Press statement prepared and Key message pilot tested and refined with input from community and other stakeholders</li> </ol> | <p>Human resource,<br/>Funding, TWG<br/>Honarium,<br/>Meeting Hall,<br/>Logistics &amp; Tools.</p> | <p>2023<br/>2025</p> | <p>State,<br/>FMOH,<br/>Partners,<br/>TWG</p>  |
| <p><b>2.5 Strengthening access to essential psychotropic medications as well as those for physical needs for NTD patients.</b></p>  | <p>Procurement of psychotropic medicines to manage common mental health conditions co-existing in skin and physical deformities caused by NTDs.</p>   | <p>Medicines,<br/>Human resource,<br/>Funding,<br/>Logistics.</p>                                  | <p>2023<br/>2025</p> | <p>State,<br/>FMOH,<br/>Partners</p>           |
| <p><b>2.6 Reduce stigma and discrimination associated with NTD morbidity.</b></p>   | <ol style="list-style-type: none"> <li>1. Encourage support groups creation for mental health enhancing activities</li> <li>2. Increase public awareness on co-morbidity of mental health disorders and suicidal tendencies in persons with NTDs</li> <li>3. Increase inclusion of persons with NTDs in community activities to reduce stigmatization</li> </ol>  | <p>Human resource,<br/>Funding,<br/>Logistics.</p>   | <p>2023<br/>2027</p> | <p>LGAs,<br/>State,<br/>FMOH,<br/>Partners</p> |
| <p><b>2.7 Strengthen monitoring and evaluation system and integrate relevant NTDs into NHMIS</b></p>  | <ol style="list-style-type: none"> <li>1.Capacity Building on the use of Score card for accountability and tracking of progress</li> <li>2.Refreshers Training on DHIS2 for National officers, and training at State level for outstanding states</li> <li>3.Training on Supervisors coverage tool for state and LGA officers.</li> </ol>   | <p>Human resource,<br/>Funding, TWG<br/>Honarium,<br/>Meeting Hall,<br/>Logistics, Tools.</p>      | <p>2023<br/>2027</p> | <p>State,<br/>FMOH,<br/>Partners,<br/>TWG</p>  |

|  |   |   |                      |                                   |
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|  | <p>4. Capacity building on Geographic information system for National and State officers</p> <p>5. Capacity Building of National officers on Advance Excel training, Pivot tables and development of Dashboard</p> <p>6. Capacity Building of National officers on the use of Power BI, TABLEU for data visualization</p> <p>7. Capacity Building of National officers on Data analytics and predictive model</p> <p>8. Scale up of DHIS2 in the progression to transition from paper-based to electronic data collection of all PC-NTDs in 36 States and the FCT</p> <p>9. Training of States on DHIS2</p> <p>10. Establishment of DHIS2 command center</p> <p>11. DHIS2 Data reporting</p> <p>12. Conduct Data Quality Assessment (DQA) in 36 States and FCT</p> <p>13. Use of the scorecard for a ccountability and tracking of implementation activities</p> <p>14. Conduct End-term evaluation of NTD Master plan 2023-2027.</p> | <p>Human resource, Funding, TWG Honorarium, Meeting Hall, Logistics, Tools.</p> | <p>2023<br/>2027</p> | <p>State, FMOH, Partners, TWG</p> |
|--|---|---|----------------------|-----------------------------------|

### Strategic Pillar 3: Operating models and culture to facilitate country ownership

|  |   |   |                    |   |
|--|---|---|--------------------|---|
| <p><b>3.1 Improved governance and coordination for implementation of Mental Health and NTD</b></p>   | <ol style="list-style-type: none"> <li>1. Develop policy to ensure collaboration between mental health services and NTD programmes in primary health care facilities and communities.</li> <li>2. Conduct advocacy and sensitization workshop on Mental health and NTDS to key stakeholders</li> <li>3. Sensitize people living with NTDS in an endemic area about the associated risk of developing mental conditions and psychosocial distress</li> <li>4. Disseminate information on availability of mental health services to people living in NTD-endemic areas</li> <li>5. Involve primary health care doctors, mental health nurses, community health workers on mental health and NTDS review meetings, monitoring, trainings and Bi-annual meetings.</li> <li>6. Provide support for the diagnosis and management of mental health conditions.</li> <li>7. Increase investment in integrated mental health, NTD and stigma reduction programmes.</li> <li>8. Strengthen national capacity to sustain implementation of efficient, integrated NTD control programmes with well-trained, supervised health care providers and managers.</li> </ol> | <p>Human resource, Logistics and communication, Meeting hall, Funding &amp; Tools</p>       | <p>2023 - 2027</p> | <p>LGAs, State, FMOH, Partners</p>                    |
| <p><b>3.2 Promote and strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding.</b></p> | <ol style="list-style-type: none"> <li>1. Conduct high level advocacy to government officials, private companies and National and International organizations for counterpart funding as well as provision of enabling environment for programme implementation</li> <li>2. Conduct Bi - annual meeting for sensitization of stakeholders on case management CM-NTDs</li> <li>3. Develop local capacity to generate technically sound plan reflecting the country's needs and priorities</li> </ol>   | <p>Human resource, Logistics and communication, Meeting hall, office equipment, Funding</p> | <p>2023 - 2027</p> | <p>LGAs, State, FMOH, Partners, Media, Consultant</p> |

|   |   |   |                    |                                    |
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|   | <p>4. Provide human resource and equipment to strengthen Advocacy, Communication and Social Mobilization (ACSM) unit</p> <p>5. Development of NTD - ACSM Guideline, strengthen Advocacy, Communication and Social Mobilization (ACSM) unit</p> <p>6. Engagement and sensitization of Joint Military Task force, Nigerian Custom Services, Red Cross, Local community vigilante and emergency rescue committee</p> <p>7. Maintenance of NTD website</p> <p>8. Case finding through local health facilities – for example, create NTD desks at health facilities</p> <p>9. Mobilization of communities for effective community engagement and ownership (Town announcers, Jingles, Talk shows, Town Hall meeting)</p> | <p>Human resource, Logistics and communication, Funding</p> | <p>2023 - 2025</p> | <p>LGAs, State, FMOH, Partners</p> |
| <p><b>3.3 Promote community inclusion, participation, and ownership of the program for optimal use of available resources</b></p> | <p>1. Strengthen Community Self-Monitoring (CSM) and follow up on reports of CSM</p> <p>2. Involve community based organizations in programme implementation and monitoring</p> <p>3. Advocacy to Civil Society Organizations that could influence/advocate for government commitment to IDMs</p> <p>4. Present awards during stakeholders meeting to community implementers for impressive performance in MAM implementation to foster sustainability</p> <p>5. Develop integrated jingles, posters and other IEC materials for community sensitization and awareness</p> <p>6. Use and distribution of the advocacy kits, IEC materials and radio jingles at State and National level</p>                         | <p>Human resource, Logistics and communication, Funding</p> | <p>2023 - 2025</p> | <p>State, FMOH, Partners</p>       |

|  |  |   |                    |                                    |
|--|--|---|--------------------|------------------------------------|
| <p><b>3.4 Strengthen national capacity to sustain implementation of efficient, integrated NTD control programmes with well-trained, supervised health care providers and managers</b></p>  | <ol style="list-style-type: none"> <li>1. Build capacity of ACSM personnel</li> <li>2. Develop and Produce IEC materials for NTDs</li> <li>3. Establish, equip and manage NTD Focal Points at zonal, State &amp; LGA Levels</li> <li>4. Conduct comprehensive advocacy tool development workshop on NTDs</li> <li>5. Conduct sensitization meetings with policy makers, line ministries, and other stakeholders on the beneficial synergy of integration at the federal, state, LGAs and community levels (including Village Health Committees)</li> </ol> | <p>Human resource, Logistics and communication, Meeting hall, Funding</p> | <p>2023 - 2027</p> | <p>LGAs, State, FMOH, Partners</p> |
| <p><b>3.5 Empower local government and authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions – strengthen integration for awareness and sensitization at all levels</b></p> | <ol style="list-style-type: none"> <li>1. Conduct advocacy and sensitization: Press briefing, talk shows on NTDs (TV &amp; Radio)</li> <li>2. Produce quarterly newsletter on NTDs and on print media</li> <li>3. Identify NTD Advocacy champion at LGA level</li> <li>4. Train Health team at LGA level on resource mobilization</li> </ol>   | <p>Human resource, Logistics &amp; Communication, Funding</p>             | <p>2023 - 2027</p> | <p>States, FMOH, Partners</p>      |

**Strategic Pillar 4: Strengthening the resources mobilization, inter sectoral collaboration for the elimination of NTD**

|  |   |   |                    |                              |
|--|---|---|--------------------|------------------------------|
| <p><b>4.1 Increase political commitment to support NTD intervention</b></p>  | <ol style="list-style-type: none"> <li>1. Development and dissemination of NTD Score card</li> <li>2. Creation of needs-driven budget line for NTD activities at National and state levels within the health system budgeting and planning framework.</li> <li>3. Increase advocacy with policy makers, private sector and community leaders</li> <li>4. Advocate with FMOH to increase funding for NTDs in the national health budget</li> <li>5. Develop proposals for funding and submit to relevant authorities</li> <li>6. Advocate for increase in policies that strengthen integration, awareness and sensitization at all levels</li> </ol>   | <p>Human resource, Logistics and communication, Funding</p>               | <p>2023 - 2027</p> | <p>FMOH, Partners</p>        |
| <p><b>4.2 Improve advocacy to pharmaceutical industry, bilateral and multilateral donors, and private philanthropists.</b></p> | <ol style="list-style-type: none"> <li>1. Map and mobilize the broad pharma, donor and private sector networks to enhance local innovative approaches and research to tackle endemic NTDs</li> <li>2. Conduct visibility and regular dialogue in supporting the achievements of targets described in the Nigeria NTD Master Plan.</li> <li>3. Capacity building, to build local, national and regional or continental capacities on resource mobilization skills, financial planning and effective resource utilization and management.</li> <li>4. Institute a cross-cutting and representative coalition, working group or committee to support the design, execution and scale-up or modification of these activities (similar to those for HIV/AIDs and Malaria)</li> <li>5. Collaborate with NAFDAC and relevant agencies</li> </ol> | <p>Human resource, Logistics and communication, Meeting hall, Funding</p> | <p>2023 - 2025</p> | <p>State, FMOH, Partners</p> |

|   |   |  |                    |   |
|---|---|--|--------------------|---|
| <p><b>4.3 Strengthen Governance and multi-sectoral coordination with Poverty alleviation programme, WASH, disability management and Education</b></p> | <p>1. Drive design and implementation of multistakeholder and multi-sectoral inclusive policies focused on One Health, horizontal system strengthening, and systems change approach.</p> <p>2. Facilitate in-country collaboration and synergizing of MDAs and organizations representative of these interwoven programs.</p> <p>3. Strengthen intersectoral collaborations between line ministries and agencies for planning and coordination.</p> | <p>Human resource, Logistics, Tools, Funding</p>                                 | <p>2023 - 2027</p> | <p>SMoH, FMOH, Partners, Communities.</p> |
| <p><b>4.4 Promote the incorporation of NTDS into countries' UHC packages, national health plans and global progress reports</b></p>                   | <p>1. Integrate all NTDS data into the NHMIS</p> <p>2. Integrate NTDS into the national eLMIS</p> <p>3. Facilitate knowledge exchanges on investing in Universal Health Coverage, focused on effective integration of NTDS</p> <p>4. Plan and Convene policy and technical discussions on reform options focused on UTC and NTDS.</p> <p>5. Integrate active surveillance of NTDS into the national community health system</p>                     | <p>Human resource, Logistics, Tools, Funding</p>                                 | <p>2023 - 2027</p> | <p>FMOH, Partners</p>                     |
| <p><b>4.5 Increase NTDS programme visibility among the Country's decision makers and influencer</b></p>   | <p>1. Host national NTDS day</p> <p>2. Domestication of the National Master plan to help and develop State Master plans in 36 States and FCT</p>  | <p>Human resource, Logistics and communication, Meeting hall, Media, Funding</p> | <p>2023 - 2027</p> | <p>FMOH, Partners, Media</p>              |
| <p><b>4.6 Strengthen Governance and multi-sectoral coordination with Poverty alleviation programme, WASH, disability management and Education</b></p> | <p>1. Increase advocacy with policy makers, community leaders, religious leaders, CBOs ETC.</p> <p>2. Domestication of sensitization messages and ICE materials to fit local context</p>  | <p>Human resource, Logistics and communication, Meeting hall, Funding</p>        | <p>2023</p>        | <p>FMOH, Partners,</p>                    |

|   |  |  |                    |                               |
|---|--|--|--------------------|-------------------------------|
| <p><b>4.7 Strengthen and foster partnership for CM-NTDs.</b></p>                        | <p>1. Conduct partners mapping</p>   | <p>Human resource, Logistics, Tools, Funding</p> | <p>2023 - 2027</p> | <p>State, FMOH, Partners,</p> |
| <p><b>4.8 Enhance resource mobilization approaches and strategies at all levels</b></p> | <p>1. Develop and submit proposals to donors and partners both national and international</p> <p>2. Engage the private sector to mobilize resources</p> <p>3. Conduct advocacy meetings with the FMOH policy makers to increase funding for NTDS</p> | <p>Human resource, Logistics, Tools, Funding</p> | <p>2023 - 2027</p> | <p>FMOH, Partners</p>         |

### Section 3.2: Toward Programme Sustainability: Intensifying Coordination and Partnerships

#### NTD Structure

There exist an NTD structure at the Federal Ministry of Health that drives control and elimination of NTDs in Nigeria (figure 15).

To align with best global practices, it is suggested that the National NTD structure should be administered under one office with subordinate Programme Managers in charge of specific diseases.

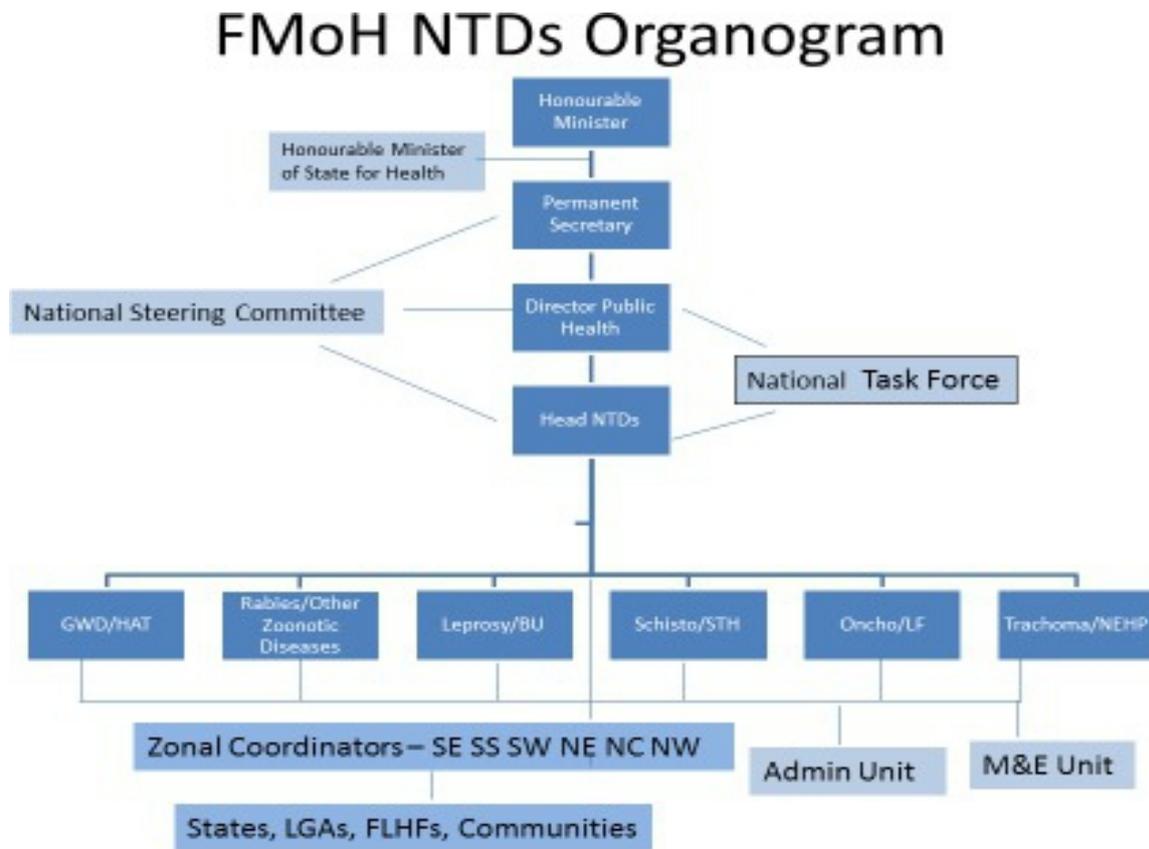


Figure 15: Organisational Chart of the FMoH and NTD National Programme

At the national level there is an NTD division headed by a National Coordinator that is in-charge of the day-to-day management of the NTD secretariat and is assisted by the various programme-specific managers. There is a technical committee, the NTD Steering Committee, which oversees programme implementation in the country. Relevant line ministries and government agencies are represented in the Steering Committee which provides the platform for collaboration of the Ministry of Health and other relevant government agencies for the implementation of NTD programme activities. This structure is replicated in the 36 States and the FCT.

## Programme coordination

| Entity  | Membership   | Terms of Reference  |
|---|--|---|
| <b>National NTD Steering Committee</b>                                      |  |   |
| Meeting frequency: Bi-annual<br>Chair: Prof. Uche Amazigo<br>Host: FMOH     | Academics and consultants                                      | <ol style="list-style-type: none"> <li>1. Support programme development for implementation of control/elimination/eradication/management of neglected tropical diseases</li> <li>2. Facilitate collaboration between FMOH, partners, NGDOS and other stakeholders in the implementation of control/elimination, eradication of NTDs and integration of activities in the health systems</li> <li>3. Provide technical advice to programme managers</li> <li>4. Facilitate financial support for ridding Nigeria of NTDs</li> <li>5. Carry out and facilitate operational research in Neglected Tropical Diseases</li> </ol> |
| <b>National NTD Secretariat (National Review Meeting)</b>                   |  |   |
| Meeting frequency: Annually<br>Chair: Director, NTDs Division<br>Host: FMOH |  |   |
| <b>National Onchocerciasis Elimination Committee (NOEC)</b>                 |  |   |
| Meeting frequency: Bi-annual<br>Chair: Prof. B.E.B Nwoke<br>Host: FMOH      | Academics<br>NGDO representatives<br>WHO<br>FMOH - Secretariat | <ol style="list-style-type: none"> <li>1. Provide technical advice on onchocerciasis elimination to the Federal Ministry of Health;</li> <li>2. Support the Government of Nigeria to develop a national guideline and road map for onchocerciasis elimination in Nigeria;</li> <li>3. Assess where and when breakpoint have been reached and recommend to the Hon. Minister of Health the localities where ivermectin treatment can be safely stopped; and</li> <li>4. Support the government in the preparation of the country's dossier for verification of Nigeria as having interrupted the</li> </ol>                  |

|   |  |   |
|---|--|---|
|   |  | transmission of onchocerciasis infection nationwide.  |
| <b>National Schistosomiasis and STH Technical Working Group</b>                                     |  |   |
| Meeting frequency: Annually<br>Chair: Prof. Uwem Ekpo<br>Host: FMoH                                 |  |   |
| <b>National Lymphatic Filariasis Technical Working Group</b>  |  |   |
| Meeting frequency: Bi-annual<br>Chair: Prof. O. Akogun<br>Host: FMoH                                |  |   |
| <b>States' NTD Technical Advisory Committees</b>  |  |   |
| Meeting frequency:<br>Chair: Annually or Bi-annually<br>(Depends on State)<br>Host: SMOHs or PHCDAs |  | <ol style="list-style-type: none"> <li>1. Provide regular technical advice to Programme Managers (PMs)</li> <li>2. Support programme development for implementation of control / elimination / eradication and management of Neglected Tropical Diseases, for instance, by providing technical support for work plan development.</li> <li>3. Facilitate collaboration between Federal Ministry of Health, State Ministry of Health, Partners / Non-Government Organisations and other Stakeholders with the aim of building sustainable partnerships in the control / elimination / eradication and management of NTD.</li> <li>4. Carry out advocacy and facilitate resource mobilization for NTD Programme.</li> <li>5. Facilitate operational research in Neglected Tropical Diseases as well as the health systems involved in their control / elimination / eradication and management.</li> <li>6. Facilitate the policy and process of integration through the inclusion of NTD Programmes activities into the broader health system in an atmosphere of strong community involvement.</li> </ol> |

## Partnership Matrix

| State                 | NTDs   | VETERINARY | WASH   | ONE HEALTH | EDUCATION | MALARIA            |
|-----------------------|--|------------|--|------------|-----------|--------------------|
| <b>1. Abia</b>        | The Carter Center  |            |  |            |           |                    |
| <b>2. Adamawa</b>     | Helen Keller International                               |            | WATER-AID/UNICEF   |            |           |                    |
| <b>3. Akwa Ibom</b>   | Helen Keller International                               |            |  |            |           |                    |
| <b>4. Anambra</b>     | The Carter Center  |            |  |            |           | Malaria Consortium |
| <b>5. Bauchi</b>      | MITOSATH/UNICEF  |            | WATER-AID/UNICEF   |            |           |                    |
| <b>6. Bayelsa</b>     | Christofell Blinden Mission/UNICEF                       |            | UNICEF   |            |           |                    |
| <b>7. Benue</b>       | SIGHT SAVERS/UNICEF                                      |            | UNICEF   |            |           |                    |
| <b>8. Borno</b>       | Helen Keller International                               |            | WATER-AID/UNICEF   |            |           |                    |
| <b>9. Cross River</b> | UNICEF/RTI   |            | UNICEF   |            |           |                    |
| <b>10. Delta</b>      | The Carter Center  |            |  |            |           |                    |
| <b>11. Ebonyi</b>     | The Carter Center  |            |  |            |           |                    |
| <b>12. Edo</b>        | The Carter Center  |            |  |            |           |                    |
| <b>13. Ekiti</b>      | UNICEF/MITOSATH  |            | UNICEF   |            |           |                    |
| <b>14. Enugu</b>      | The Carter Center  |            | WATER-AID/UNICEF   |            |           |                    |
| <b>15. Gombe</b>      | Amen Health Care and Empowerment Foundation/UNICEF       |            | UNICEF   |            |           |                    |
| <b>16. Imo</b>        | The Carter Center  |            |  |            |           |                    |
| <b>17. Jigawa</b>     | CBM International/ CBM Global Disability Inclusion/HANDS |            |  |            |           | Malaria Consortium |
| <b>18. Kaduna</b>     | SIGHTSAVERS  |            | SIGHTSAVERS  |            |           | Malaria Consortium |
| <b>19. Kano</b>       | CBM International/HANDS                                  |            |  |            |           | Malaria Consortium |
| <b>20. Katsina</b>    | Helen Keller International                               |            |  |            |           | Malaria Consortium |
| <b>21. Kebbi</b>      | SIGHTSAVERS  |            |  |            |           |                    |
| <b>22. Kogi</b>       | SIGHTSAVERS  |            |  |            |           |                    |
| <b>23. Kwara</b>      | SIGHTSAVERS  |            |  |            |           |                    |
| <b>24. Lagos</b>      | MITOSATH/EVIDENCE ACTION                                 |            | WATER-AID/UNICEF   |            |           |                    |
| <b>25. Nasarawa</b>   | The Carter Center  |            |  |            |           |                    |
| <b>26. Niger</b>      | MITOSATH/UNICEF  |            | UNICEF   |            |           | Malaria Consortium |
| <b>27. Ogun</b>       | CBM/EVIDENCE ACTION/UNICEF                               |            | UNICEF   |            |           |                    |
| <b>28. Ondo</b>       | MITOSATH/UNICEEF   |            | UNICEF   |            |           |                    |
| <b>29. Osun</b>       | Amen Health Care and Empowerment Foundation/UNICEF       |            | UNICEF   |            |           |                    |
| <b>30. Oyo</b>        | EVIDENCE ACTION/CBM/UNICEF                               |            | UNICEF   |            |           |                    |
| <b>31. Plateau</b>    | The Carter Center  |            |  |            |           |                    |
| <b>32. Rivers</b>     | CBM/EVIDENCE ACTION/UNICEF                               |            | UNICEF   |            |           |                    |
| <b>33. Sokoto</b>     | SIGHTSAVERS  |            |  |            |           |                    |
| <b>34. Taraba</b>     | MITOSATH   |            |  |            |           |                    |
| <b>35. Yobe</b>       | CBM International/CBM Global Disability Inclusion/HANDS  |            | WATER-AID/UNICEF   |            |           |                    |
| <b>36. Zamfara</b>    | SIGHTSAVERS  |            | UNICEF   |            |           |                    |
| <b>37.FCT</b>         | CBM Global Disability Inclusion/HANDS                    |            | CBM Global Disability Inclusion/HA NDS, WATER-AID/UNICEF |            |           |                    |

### Section 3.3: Assumptions, Risks and Mitigations

Risk is the process of examining how likely risk will arise in the implementation of NTD programme. It also involves examining how the programme outcome and objectives might change due to the impact of the risk. The impact could be in terms of schedule, quality and cost.

Risk mitigation is the process of developing options and actions to enhance opportunities and reduce threats to the programme objectives. Risk mitigation progress monitoring includes tracking identifiable risks, identifying new risks, and evaluation risk process effectiveness throughout the programme period

**Table 23: Assumptions, Risks and Mitigations for Nigeria NTD programmes**

| Risk name                            | Risk definition  | Rating        |           | Mitigating actions  |
|--------------------------------------|--|---------------|-----------|---|
|                                      |  | Likelihood    | Severity  |   |
| Low prioritization of CM-NTDs        | Limited awareness and implementation of CM-NTDs  | Highly Likely | Critical  | Increased advocacy with policy makers, private sector and community leaders through radio jingles, TV talk shows and distribution of IEC materials  |
|                                      |  | Critical      | High      | Development of IEC materials, airing of radio and TV talk shows   |
|                                      |  | High          |           |   |
| Paucity of data on CM-NTDs           | Inadequate reported data on the distribution of CM-NTDs  | Highly Likely | Critical  | Intensified collection and collation of reported data on CM-NTDs from the facilities and integration into the NHMIS   |
|                                      |  | Critical      | Very High | Intensify active surveillance, case confirmation and management on CM-NTDs  |
|                                      |  | Very High     |           |   |
| Inadequate Funding                   | Low prioritization of monitoring and evaluation and research on NTDs by government, donors and implementing partners | Highly Likely | Critical  | Advocate for the allocation and utilization of the 5% aid for M&E, research as in the national research policy 2016. Reinvigorate NTDs resource mobilization sub-committee for better productivity. Intensify advocacy visit to policy makers for improved resource allocation, budgeting and releases. Identify potential funders and develop proposal for funding request. Advocate to already existing funders for improved funding support and device strategies ameliorate donor fatigue |
|                                      |  | Critical      | High      | Publish outcomes of research work in peer review journals   |
|                                      |  | High          |           |   |
| Inadequate Laboratory infrastructure | Lack of dedicated laboratories for NTD specimen analyses including for molecular diagnosis                           | Highly Likely | Critical  | Approach relevant stakeholders for the provision of laboratory spaces   |
|                                      |  | Critical      | High      | Approach partners for provision of equipment and capacity building of required laboratory personnel   |
|                                      |  | High          |           |   |

|                           |   |                   |               |   |
|---------------------------|---|-------------------|---------------|---|
| Poor coordination         | Fragmentation due to verticalization of programmes design and implementation  | <i>Likelihood</i> | Highly Likely | Develop co-implementation guidelines, integrated IEC materials, SOPs, training modules and incorporate/develop joint M&E processes with other units, divisions, line ministries and agencies. Integrate NTDS into the national e-LMIS |
|                           |   | <i>Severity</i>   | Critical      | Advocacy to secure buy-in of policy makers and program managers within the health sector and intersectorary   |
|                           |   | <i>Risk Level</i> | Very High     |   |
| Human Capital Development | unavailability of policy documents and trained personnel for referral of suspected CM-NTDs as Yaws, Leishmaniasis etc.  | <i>Likelihood</i> | Highly Likely | Develop the relevant policy documents in collaboration with key stakeholders  |
|                           |   | <i>Severity</i>   | Critical      | Set-up a joint TWG for CM-NTDs and TWG in the States  |
|                           |   | <i>Risk Level</i> | High          |   |
| Insecurity                | Banditry, Communal clashes, Kidnap for ransome, Civil unrest disrupts programme delivery causing implementation delays e.g. Borno, Katsina, kebbi, Sokoto, Taraba, Niger, Yobe Zamfara. | <i>Likelihood</i> | Highly Likely | Work with relevant State security agencies  |
|                           |   | <i>Severity</i>   | Critical      | Security assessments and surveillance prior to activity implementation  |
|                           |   | <i>Risk Level</i> |               | Use of specific standard operation procedures to safely implement activities.   |
| Political instability     | Change in administration leading to setbacks in implementation and enforcement of already laid down policies that affect programme delivery,  | <i>Likelihood</i> | Likely        | Prompt onboarding of staff in new administration  |
|                           |   | <i>Severity</i>   | Major         | Advocacy visits for orientation, sensitization and awareness creation with advocacy kits.   |
|                           |   | <i>Risk Level</i> |               | States should have a laid down plan that promotes continuity of government policies   |
| Environmental hazards     | Flooding, fire outbreaks due to weather conditions cause delay in implementation including Covid-19 pandemic  | <i>Likelihood</i> | Likely        | Proper waste disposal   |
|                           |   | <i>Severity</i>   | Major         | Involvement of relevant line ministries and agencies (NESREA,, NEMA and Environment) for preventive measures and emergency preparedness   |

|                                       |  |                   |                      |   |
|---------------------------------------|--|-------------------|----------------------|---|
| <b>Gender inequality</b>              | Poor geographic and therapeutic coverage during implementation, poor access to health care services, poor health seeking behaviour | <i>Risk Level</i> |                      |   |
|                                       |  | <i>Likelihood</i> | <b>Likely</b>        | Involvement of more female community implementers   |
|                                       |  | <i>Severity</i>   | <b>Moderate</b>      |   |
| <b>Lack of government ownership</b>   | Difficulties in sustainability of programmes and implementation,   | <i>Risk Level</i> |                      |   |
|                                       |  | <i>Likelihood</i> | <b>Highly Likely</b> |   |
|                                       |  | <i>Severity</i>   | <b>Critical</b>      | Continued advocacy visits to government at all levels for sensitization and awareness creation with advocacy kits                   |
| <b>import issues</b>                  | delays in receiving NTD medicines and commodities/consumables,   | <i>Risk Level</i> |                      | Advocate to the policy makers at all levels for designation adequate human resources for NTDs                                       |
|                                       |  | <i>Likelihood</i> | <b>Highly Likely</b> | Commence early reporting of the previous year implementation and early request of medicine needed for the next implementation cycle |
|                                       |  | <i>Severity</i>   | <b>Critical</b>      | Liaise with NAFDAC, Customs and Ministry of Finance for timely release of NTD commodities from the port                             |
| <b>Inflation</b>                      | Continuous rising cost of implementation, high cost of locally unavailable materials and technology                                | <i>Risk Level</i> |                      |   |
|                                       |  | <i>Likelihood</i> | <b>Highly Likely</b> | Flexible budgeting  |
|                                       |  | <i>Severity</i>   | <b>Critical</b>      |   |
| <b>Competing programme priorities</b> | Personnel attitude, preference, and attrition due to incentives from non-NTDs programmes   | <i>Likelihood</i> | <b>Highly Likely</b> | Integration and collaboration with other health programmes  |

|  |                   |                  |  |
|--|-------------------|------------------|--|
|  | <b>Severity</b>   | <b>Critical</b>  | Include criteria for recruitments of CDDs in the existing SOPs of all NTDS programme, standardize the allowance of CDDs to be at par with other competing programmes |
|  | <b>Risk Level</b> | <b>Very High</b> |  |

### Section 3.4: Performance and Accountability Framework

In the table below are the strategic objectives, and the indicators, targets and date to track performances are provided.

| Strategic Priority   | Performance Indicators  | Target            | Date             |
|--|---|-------------------|------------------|
| <b>Scale up integrated preventive chemotherapy to achieve 100% geographic coverage and treatment access to lymphatic Filariasis and Onchocerciasis, Soil transmitted Helminths, Trachoma and Schistosomiasis</b> | Manual developed and disseminated to all states                                       | 36 states and FCT | 2023             |
|  | Number of Health Workers trained on Integrated CM-NTDs                                | 100,000 Hws       | 2027             |
|  | Integrated CM NTDS facility register developed, printed, and distributed              | 40,000            | 2027             |
|  | Referral forms developed, printed, and distributed                                    | 20,000            | 2025             |
|  | Number of Health workers trained on CM-NTDs Case finding at all levels                | 100,000 HWs       | 2025             |
|  | No of Laboratory Scientists trained on PCR  | 100               | 2025             |
|  | Number of RDT and DPP test kits distributed   | 5000              | 2025             |
|  | No CHEW trained on CM NTD case finding.   | 387, 000          | 2025             |
|  | No of health facility with medicine and commodities for CM NTD                        | 1000              | 2027             |
|  | Number of Lymphodema patients who received home base self-care kits                   | 10,000 cases      | Yearly till 2027 |
|  | Number of health care workers trained   | 100,000           | 2025             |
|  | Number of patients who received at least two visit call after surgery within 6 months | 3,500 cases       | Yearly till 2027 |
|  | Visual aid for case finding developed and disseminated                                | 20,000 copies     | Yearly till 2027 |
|  | Number of patients with CM NTD who received assistive device                          | 10,000 patients   | Yearly till 2027 |
|  | Number of FMOH Staff trained on CM-NTD Management                                     | 200 staff         | Yearly till 2027 |
| Case management NTD reported established through DHIS-2  | All endemic CM NTDS   | Yearly till 2027  |                  |

|  |  |                                  |                  |
|--|--|----------------------------------|------------------|
|  | Integrated supervision tool and check list for Case Management NTDs at all levels developed and disseminated | 2000 copies of checklist printed | Yearly till 2027 |
|  | Number of health facility who received feedback on improving data quality per geopolitical zone per quarter. | 30 DQA at zonal levels           | Yearly till 2027 |
|  | Number of traditional healers and religious leaders trained on identification of CM NTDs                     | 15,480                           | Yearly till 2027 |
|  | Number of people who received incentive (20k) after a case is confirmed                                      | 100                              | Till 2025        |
| <b>Prioritize and strengthen monitoring and evaluation to track progress and decision making towards aligned targets</b> | Prevalence of FGS in Nigeria determined  | 36 states and FCT                | Yearly till 2027 |
|  | Snail control lab established  | 3                                | 2025             |

**Table 21b. Performance Indicators for Pillar 2: Intensify cross-cutting approaches**

| Strategic Priority  | Performance Indicators  | Target | Date             |
|---|---|--------|------------------|
| <b>Mainstream CM-NTDs delivery platforms within the national health system</b>            | CM NTDs reporting data tools developed and link to DHIS2                      |        |                  |
| <b>Integrate safety across NTD planning, implementation, and monitoring</b>               | Percentage of NTD clinic with psychotropic medicine                           | 50%    | Yearly till 2027 |
| <b>Strengthen monitoring and evaluation system and integrate relevant NTDs into NHMIS</b> | Number of States implementing DHIS2 for integrated data reporting of NTDs     |        |                  |
| <b>Strengthen monitoring and evaluation system and integrate relevant NTDs into NHMIS</b> | Number of staff trained on Monitoring and Evaluation techniques at all levels | 200    | Yearly till 2027 |

**Table 21c. Performance Indicators for Pillar 3: Operating Models and culture to facilitate country ownership**

| Strategic Priority  | Performance Indicators   | Target | Date             |
|---|--|--------|------------------|
| <b>Improved governance and coordination for implementation of Mental Health and NTD</b> | Mental health is integrated into NTD program implementation at all levels                              |        |                  |
|   | Percentage of population who demonstrated Knowledge and awareness of Mental Health associated with NTD | 50%    | 2027             |
|   | Number of NTD staff at all levels trained on MhGAP   | 2000   | Yearly till 2027 |

|   |   |      |                  |
|---|---|------|------------------|
| <b>Promote community inclusion, participation, and ownership of the program for optimal use of available resources</b>  | Number of CBO engaged in NTD social mobilization  | 100  | Yearly till 2027 |
| <b>Strengthen national capacity to sustain implementation of efficient, integrated NTD control programmes with well-trained, supervised health care providers and managers</b>  | Number of staff trained on advocacy, communication, and social mobilization at all levels |      | Yearly till 2027 |
|   | Advocacy tool developed and disseminated  |      | Yearly till 2027 |
| <b>Empower local government and authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions – strengthen integration for awareness and sensitization at all levels</b> | Quarterly newsletter produced and disseminated  | 20   |                  |
|   | Percentage of LGA in Nigeria with NTD Champions   | 100% | Yearly till 2027 |

**Table 21d. Performance Indicators for Pillar 4: Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDS**

| Strategic Priority   | Performance Indicators   | Target     | Date             |
|--|--|------------|------------------|
| <b>Increase political commitment to support NTD intervention</b>   | NTD Scorecard developed and disseminated   |            | Yearly till 2027 |
|  | Budget line for NTD is created in appropriation bill                                 |            | Yearly till 2027 |
|  | Increased NTD funding allocation by the FMOH   | 1 billion  | Yearly till 2027 |
| <b>Improve advocacy to pharmaceutical industry, bilateral and multilateral donors, and private philanthropists.</b>                        | Number of private sector company supporting NTD intervention in Nigeria              | 100        | Yearly till 2027 |
|  | Number of staff trained on resource mobilization at all levels                       | 50         | Yearly till 2027 |
|  | Number of working groups committee inaugurated to support NTD program implementation | 5          | 2025             |
| <b>Strengthen Governance and multi-sectoral coordination with Poverty alleviation programme, WASH, disability management and Education</b> | Number of program coordination meeting held with all stakeholders in attendance      |            |                  |
| <b>Promote the incorporation of NTDS into countries' UHC packages, national health plans and global progress reports</b>                   | Number of program planned and co-implemented with NTDS                               | 5 programs | 2023 till 2027   |

|   |  |                        |                         |
|---|--|------------------------|-------------------------|
| <p><b>Increase NTDs programme visibility among the Country's decision makers and influencer</b></p> | <p>Number of states with NTD master plan</p>               | <p>36 and FCT</p>      | <p>2023</p>             |
| <p><b>Enhance resource mobilization approaches and strategies at all levels</b></p>                 | <p>Total amount of money mobilized from private sector</p> | <p>5 billion naira</p> | <p>Yearly till 2027</p> |

**• PART FOUR: BUDGETING FOR IMPACT: ESTIMATES •**

Table 17.2: Summary Budget for National Activities

| Strategic Pillar                                    | Priorities  | COST(Naira)   |
|---|---|---------------|
| <b>Pillar 1. Accelerating programmatic action</b>   | Scale up integrated preventive chemotherapy to achieve 100% geographic coverage and impact assessment of lymphatic filariasis, Onchocerciasis, Soil transmitted Helminths, Trachoma and Schistosomiasis | 3,440,711,150 |
|   | 1.2 Scale up mapping for case management NTDs diseases (Snakebite Envenoming, Yaws, Rabies, Leishmaniasis Mental health co morbidity) and Human African Trypanosomiasis)                                | 1,213,926,250 |
|   | 1.3 Scale-Up Access to Case management Interventions, Treatment & Service Delivery  | 42,345,000    |
|   | 1.4 Strengthening access to people-centered mental healthcare for people with Skin NTDs in Nigeria.   | 39,106,000    |
|   | 1.5 Prioritize and strengthen monitoring and evaluation to track progress and decision making towards aligned targets.  | 875,732,500   |
|   | 1.6 Strengthen Programme coordination.  | 300,832,000   |
|   | 1.7 Ensure timely, safe, and effective supply chain management of quality assured NTD Medicines and other products up to the last mile  | 275,335,700   |
| <b>Pillar 2. Intensify cross-cutting approaches</b> | 2.1 Strengthen identified platforms with similar delivery strategies and interventions (MAM, skin NTDs, Morbidity management, SBCC, WASH etc) for integrated approaches across NTDs                     | 96,880,000    |

|  |  |  |
|--|--|--|
|  | <p>2.2 Mainstream CM-NTDs delivery platforms within the national health system</p> <p>2.3 Strengthen cross-sectoral collaboration and ensure coordinated, integrated action in primary health care and in communities</p> <p>2.4 Integrate safety across NTD planning, implementation, and monitoring.</p> <p>2.5 Strengthening access to essential psychotropic medications as well as those for physical needs for NTD patients.</p> <p>2.6 Reduce stigma and discrimination related to NTD morbidity and livelihood support.</p> <p>2.8 Enhance disease surveillance, for skin NTD and CM NTD monitoring, post elimination and operational research</p> | <p>90,402,000</p> <p>148,410,001</p> <p>75,274,000</p> <p>90,402,000</p> <p>511,803,930</p> <p>402,821,892</p> |
| <p><b>Pillar 3.<br/>Operating Models and culture to facilitate country ownership</b></p> | <p>3.1 Improve governance and coordination for implementation of Mental Health and NTD</p> <p>3.2 Promote and strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding.</p>   | <p>199,094,600</p> <p>35,672,820</p>   |

|  |   |   |
|--|---|---|
|  | <p>3.3 Promote community inclusion, participation, and ownership of the program for optimal use of available resources.</p> <p>3.4 Strengthen national capacity to sustain implementation of efficient, integrated NTD control programmes with well-trained, supervised health care providers and managers.</p> <p>3.5 Empower local government and authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions.</p> <p>3.6 Increase awareness of mental health and suicidal tendencies in persons with NTDs and deformities through community support groups, IEC, inclusion in communal activities, etc.</p> | <p>90,711,400</p> <p>382,331,420</p> <p>50,000,000</p> <p>20,000,000</p>                  |
| <p><b>Pillar 4.<br/>Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs</b></p> | <p>4.1 Increase political commitment to support NTD intervention.</p> <p>4.3 Strengthen Governance and multi-sectoral coordination with Poverty alleviation programme, WASH, disability management and Education</p> <p>4.4 Promote the incorporation of NTDs into countries’ UHC packages, national health plans and global progress reports</p> <p>4.5 Increase NTDs programme visibility among the Country’s decision makers and influencer</p> <p>4.6 Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.</p>   | <p>9,087,500</p> <p>30,500,000</p> <p>13,243,200</p> <p>156,450,000</p> <p>50,442,000</p> |
|  |   | <p><b>8,641,515,363</b></p>   |

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