**Data requirements**

National NTD policy, Onchocerciasis programme strategic plans and associated documents

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| **Facility map** | **What’s required** | **Description** | **Available data sources** |
| Public Health Facility (locations) | Facility Master List (FML) | List of public health facilities including:   * Facility name * Facility code (if available) * Geolocations (latitude and longitude), * Facility type (public, informal private, formal private) * Facility level (e.g. community, primary healthcare, district hospital, regional referral hospital, national) * Services offered, e.g. –RDT testing, ELISA testing (general, not only Oncho related) | Available via FIND HAT Project  Data to be validated as up to date and complete. |
| **Demand** |  |  |  |
| Number of individuals tested for Onchocerciasis | Individuals tested for Onchocerciasis | Number of individuals tested for Onchocerciasis, disaggregated by:  Reason for testing (OEM, stop MDA, post-treatment surveillance)  By testing site  By age (adult/child)  By referring community or health facility  Where individuals tested by both RDT and ELISA, comparison of results if possible (i.e. RDT neg/ELISA neg, RDT neg/ELISA pos, RDT pos/ELISA pos, RDT pos/ELISA neg)  Ideally data from past 1-3 years (or from most recent full year) | Data requested from Onchocerciasis programme coordinator /MOH |
| **Diagnostic Network** |  |  |  |
| Referral pattern | Design of referral network | Referral flows from communities to testing sites for RDT/ELISA  Referral flows from RDT testing site to ELISA testing site  Constraints on how future referrals could be designed – e.g. are cross-district or cross-regional referrals allowed | Information to be requested from MOH  District or sub-district health management (however it is called in DRC) |
| Testing volumes | Number of tests performed | Number of Onchocerciasis tests performed, disaggregated by:   * Test type * Reason for testing (OEM, stop MDA, post-treatment surveillance) * By testing site * By age (adult/child) * By referring community or health facility * Where individuals tested by both RDT and ELISA, comparison of results if possible (i.e. RDT neg/ELISA neg, RDT neg/ELISA pos, RDT pos/ELISA pos, RDT pos/ELISA neg) * Ideally data from past 1-3 years (or from most recent full year) | Onchocerciasis programme coordinator,  NTD programme |
| Testing capacity | Maximum testing capacity | Maximum capacity of testing sites (number of tests that can be performed per month)   * DBS collection: * RDT testing: * ELISA testing: | Data requested from Onchocerciasis programme coordinator /MOH |
| **Costs** |  |  |  |
| Programme costs | Cost per person tested | Costs of programme activities, broken down by budget component (HR, equipment, supplies, overhead, infrastructure etc.) and by programme element (OEM, stop MDA, surveillance etc.) | Data requested from Onchocerciasis programme coordinator /MOH  MOH for actual programme costs (broken down by cost elements)  Plus Literature review, including the following:  Kim, PLOS NTD 2015 (multi-country data and assumptions)  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4567329/pdf/pntd.0004056.pdf>  Bessell PR, Lumbala C, Lutumba P, Baloji S, Bieler S, Ndung'u JM (2018) Cost-effectiveness of using a rapid diagnostic test to screen for human African trypanosomiasis in the Democratic Republic of the Congo. PLoS ONE 13(9): e0204335. https://doi.org/10.1371/journal.pone.0204335  **Considerations:**  How to allocate costs to diagnostic component of the programme, versus other costs?  How should we consider costs for Oncho, if they are conducted together with other interventions? |
| Transport Costs | Cost of the sample referral systems | Costs of sample transportation across different levels of the network.   * Which sample transport mechanisms are used? * Are costs based on per sample or per journey? * Standard or variable cost per distance? * Is transport on demand or regular scheduled service? * Are samples for Oncho surveillance transported separately or together with other samples? | Gather data from key stakeholder interviews, use benchmark data on transport costs where actual data are unavailable. |
| Equipment Costs - operating |  | Warranty/service and maintenance costs, cost of reagents and supplies. Include   * Shipment * Human resources * Infrastructure, * Training, QA etc. | Gather data from MOH/key stakeholder interviews  FIND to conduct costing analysis based on cost inputs |
| Equipment Costs - capital |  | Purchase costs of instruments, including shipment, customs costs, etc. | Gather data from MOH/key stakeholder interviews |

**Scenario specific questions**

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| **Domain** | **Area of interest** | **Specific questions** |
| Central level coordination | Would staff from the central coordination accompany surveillance activities in the field | 1. How many people travel? 2. How do they travel – always by road, or by air to distant structures? 3. How is road travel done – private vehicle, programme vehicle, rented vehicle? 4. What is the cost for the vehicle rental (if applicable)? 5. What rate (allowances/per diems) would people from the central coordination receive? |
| Provincial level coordination | Is there a provincial level coordination | 1. Is this based out of the Provincial Hospital? 2. Is the provincial coordination dedicated to oncho, or NTDs? 3. Do all province use the same model for managing oncho? 4. How many people from the provincial level will be involved in a typical OEM activity? 5. What rate (allowances/per diems) would people from the province receive? |
| OEM | When conducting OEM, how would the communities be sampled? | 1. Would the survey team sample the first frontline communities, perform Ov16 RDT/ELISA, and based on the outcome return to sample the second line communities? Or the team will sample all the communities in one travel? 2. How many communities can be sampled in a day, assuming 50-100 participants per community? 3. Are some activities conducted alongside LF mapping? |
| Surveillance activities | Are surveillance activities always carried out in the same way, or do they differ by campaign or province? | Any critical differences between screening campaigns? |
| Surveillance – health facilities | When oncho surveillance is conducted from health facilities | 1. Do all levels of health facility participate – from posto de saude upwards – do all health facilities have capacity for testing? 2. Do local staff do the testing, or is testing conducted or supervised by provincial level staff? 3. What training do local level staff receive? 4. How many people would local facilities test in a single day? 5. Is the surveillance accompanied by a sensitisation campaign? If yes, what is the cost involved? 6. What renumeration do health facility staff receive? 7. What is the experience with respect to time to complete testing of collected samples, and is there a problem with backlogs? At district/provincial level facilities and at national level? |
| Surveillance - communities | When oncho surveillance is conducted in the community | 1. What is the typical composition of a screening team? 2. How does the team move in the field – what transport do they use, where do they stay? 3. Where in the community do the team base themselves for conducting surveillance? 4. How many people would the team screen during a single day? How many communities in a single day? 5. Are they preceded by a sensitisation campaign? What is the cost involved? 6. What renumeration do the team members receive? |
| Practicalities |  | 1. If RDT is done on DBS would this be in the capital, at the provincial level or the municipality? 2. Do the provincial level coordinators have vehicles for screening, or do they hire them? If vehicles are hired, at what cost per day? |