

Indicator description	Number of people receiving treatment or care for one or more neglected tropical diseases (disaggregated by type of intervention received)
Indicator Type	Peak year
Rationale	<p>Neglected Tropical Diseases (NTDs) are a group of diseases that affect the world's poorest and most marginalised people, predominantly in remote and hard-to-reach communities, which lack access to safe water, sanitation, and health services.</p> <p>NTDs affect 1.6 billion people globally, and cause a range of health outcomes, including severe pain, long-term disability, chronic illness, irreversible blindness, disfiguration and death. These outcomes also result in further socio-economic impacts, such as out-of-pocket health expenditures, lost livelihoods, stigma and social exclusion. NTDs inhibit children to learn and develop to their full potential and prevent adults from work.</p> <p>Reaching people with preventive or curative interventions for NTDs can avoid long-term health complications or the development of disabilities. Large scale intervention can also reduce overall transmission of NTDs, which over time will support their effective control or elimination.</p>
Technical definition	<p>The indicator captures the number of people receiving one or more of the following interventions which aim to prevent, cure or manage an NTD.</p> <p>Preventive interventions:</p> <ul style="list-style-type: none"> • Lymphatic Filariasis (albendazole + ivermectin or diethylcarbamazine citrate) • Soil transmitted helminths (albendazole or mebendazole) • Schistosomiasis (praziquantel) • Onchocerciasis (ivermectin) • Trachoma (azithromycin) • Guinea worm (cloth filters – estimated using number of households and average household size) <p>Curative treatments:</p> <ul style="list-style-type: none"> • Visceral leishmaniasis (AmBisome or Paromomycin and SGG) <p>Morbidity management interventions:</p> <ul style="list-style-type: none"> • Hydrocele (surgery) • Lymphatic filariasis swelling of lower limbs (morbidity management) • Trichiasis (surgery)
Data calculations	Data provided by partners should detail the number of interventions provided, disaggregated by disease, intervention type, country, age group (pre-school aged children, school aged children, adults), district

	<p>(or other sub-national geographical unit), gender and disability status.</p> <p>From this, the “peak” interventions per district and age group (over time and across disease) should be calculated, to avoid potential double counting (e.g. we couldn’t aggregate the number of interventions delivered for multiple diseases, as these may be provided to the same people).</p>
Data sources	Data for this indicator are reported by implementing partners, and are generally obtained through national NTD data reporting systems, managed by the Ministry of Health.
Reporting roles	DFID spending departments take primary responsibility for ensuring adequate baseline data is available and that programmes include suitable indicators and requirements for ongoing monitoring.
Baseline data	For DFID reporting purposes, 2016 calendar year baseline is used with achieved results being reported from 2017 onwards.
Return format	<p>A spreadsheet containing a record of all calculations should be provided, showing the number of people reached with (a) preventive, (b) curative, (c) morbidity management interventions and (d) an aggregate reach.</p> <p>The return should make clear how double counting has been avoided (e.g. by using peak years by district and age group), and should outline any specific concerns around data quality.</p>
Data dis-aggregation	Data should be disaggregated by the type of intervention provided, gender and disability status (where available). It may also be possible to provide disaggregation by age group (pre-school age, school age, adult) and sub-national geography (e.g. district).
Data availability	Annually
Time period/lag	Achieved results are made available from NTD programmes in February of each year, hence the time-lag for reporting should be minimal.
Quality assurance measures	<p>There are three layers of quality assurance (QA) in place, not including Standard QA processes put in place by partners, national Ministries of Health and the World Health Organization.</p> <ol style="list-style-type: none"> 1. Programme teams assess data quality during annual reviews and project completion reviews. 2. Policy Division collate data from partners, perform calculations, and identify any potential data quality concerns. 3. Finance and Corporate Performance Division review the data submission and calculations, and communicate any issues back to Policy Division for resolution.
Data quality	Variation in data quality is anticipated across countries, as a factor of the

quality of training provided to community based health volunteers and health workers who carry out interventions and complete data reporting tasks, national health data reporting systems in use, and the overall capacity of Ministries of Health.

Implementing partners and the World Health Organization work with national Governments to strengthen data reporting systems, although DFID has little control over the final quality of data reported. This indicator is closely aligned to SDG indicator SDG indicator 3.3.5 (number of people requiring interventions against neglected tropical diseases), and as such uses data which is reported by Ministries of Health to the WHO to support the monitoring of the SDG indicator. This alignment will ensure that our results reporting is using the highest quality data available on the reach of our NTD programmes.

To avoid counting individuals more than once where they may be receiving multiple interventions, the peak reach per district and age group (across interventions and time) is used. It is important to note that this is likely to be an underestimate of our programmes overall reach. However, due to the lack of individual based data, it is not possible to achieve a full enumeration of beneficiaries, while avoiding double counting, in any other way.

The data for the number of individuals receiving preventive interventions for Guinea Worm Disease is likely to be less accurate than the rest of the data used, as this is an estimated reach figure based on the number of households provided with cloth water filters and the average household size in intervention villages (this is calculated by our implementing partners). However, as we are now very close to the eradication of Guinea Worm Disease, partner data on at-risk communities is very strong, and so the level of error should be minimal.

Statistics advisers in DFID undertake quality assurance of the results data and attempt to minimise the source of any errors although there is a risk that errors may still exist.