Session 1: Introductions and adoption of the meeting agenda

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8TH Regional Review Group Meeting of Preventive Chemotherapy NTDs

13th – 14th November 2023

The Grand Lancaster Hotel

Brazzaville (Republic of the Congo)

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Introductions & Welcome remarks

Dr Elizabeth Juma – ESPEN Team Lead

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Security briefing, Preventing & Responding to Sexual Abuse policy, and meeting logistics

Mr Ondongo Juslin – AF/RGO/GMC/SEC

ESPEN Administrative team

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Meeting Objectives and Agenda

Co-chairs

Dr Elizabeth Osim Elhassan

Dr. (Mr.) Teshome Gebre Kanno, PhD, FASTMH

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8th Regional Programme Review Group Meeting Objectives

- Introduce new members of the PC-NTD RPRG and apprise them of the terms of reference and standard operating procedures
- Provide an overview of regional progress towards global targets of elimination of PC NTDs
- Provide an overview of cross-cutting interventions to support implementation of PC-NTD interventions
- To identify solutions for specific challenges with 4 PC NTDs, encountered by endemic countries

Agenda – Day 1

Session 1: Introductions and adoption of the meeting agenda		
08:00 – 08:30	Registration	Secretariat
Session 1: Official Opening		
08:30 – 09:10	Introductions	ESPEN
	Welcome remarks	Elizabeth Juma Co-Chairs
09:10 – 09:30	Security briefing Preventing and responding to sexual abuse Administrative announcements	Mr Ondongo Juslin
09:30 – 09:50	Objectives of the Meeting Adoption of the RPRG Meeting Agenda Report on actions points from 7th RPRG Meeting	ESPEN

Session 2: (Closed) Review and adoption of operational guidelines for the RPRG		
09:50 -10:40	Review and adoption of SOPs, Modus Operandi, and TOR	RPRG Closed Session
10:40 – 11:00	Health Break	
11:00 – 11:20	Updates from Global NTD Programme	Daniel Dagne, WHO HQ
Session 3: Regional Disease Trends		
11:20 – 11:30	Introduction and context	Elizabeth Juma
11:30 – 11:45	Trachoma	Amir Kello
11:45 – 12:10	Schistosomiasis and soil transmitted helminthiasis	Pauline Mwinzi
12:10 – 12:35	Onchocerciasis and lymphatic filariasis	Didier Bakajika
12:35 – 13:00	Discussions	
13:00 – 14:00	Lunch Break	
Session 4a: Challenges affecting progress – Schistosomiasis and Soil T. Helminthiases		
14:00 – 14:30	Schistosomiasis	Pauline Mwinzi & Amadou Garba
14:30 - 15:00	Soil transmitted helminthiasis	Pauline Mwinzi & Denise Mupfasoni
15:00 – 15:20	Break	
15:20 – 16:30	Discussions and RPRG recommendations	RPRG
16:30	End of Day 1	

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Agenda – Day 2

Session 4b: Challenges affecting progress – Onchocerciasis and Lymphatic filariasis		
08:30 – 08:35	Welcome	Co-chairs
08:35 – 08:55	Onchocerciasis	Didier Bakajika
08:55 – 09:20	Lymphatic Filariasis	Didier Bakajika
09:20 – 10:20	Discussion and RPRG recommendations	RPRG
10:20 – 10:40	Break	
Session 5: Information session on cross-cutting activities: Data Management		
10:40 – 11:40	ESPEN Portal, current country progress analytics, Implementation Unit Planner and RPRG data review tools	ESPEN and Linksbridge
11:40 – 12:20	RPRG interaction with ESPEN portal and discussions	Jorge Cano
12:20 – 12:40	Updates on NTD indicators on ALMA scorecard	ALMA
12:40 – 12:45	Discussions	
12:45 – 13:00	Group Photograph	ESPEN Secretariat
13:00 – 14:00	Lunch Break	

Session 6: Information session on cross-cutting activities: Programme implementation planning		
14:00 – 14:20	Modelling to guide programmatic decision making	CEMA
14:20 – 14:40	Supply Chain Management	Tuan, Le (WHO HQ)
14:40 – 15:00	Discussions	RPRG
15:00 – 15:20	Break	
15:20 – 15:50	Summary of recommendations and actions	Rapporteurs
15:50 – 16:00	Meeting Evaluation – Online	ESPEN
16:00 – 16:15	Vote of Thanks and Closing remarks	RPRG Co-Chairs ESPEN
16:15	Meeting Ends	

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Report on actions points from 7th RPRG Meeting 16 – 18 October 2018 Berlin, Germany

Dr Elizabeth Juma – ESPEN Team Lead

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To WHO (1)

Recommendation	Action taken
Strengthen communication and engagement of RPRG members	RPRG meetings have re-commenced after a 3-year break. Regular communications as advised by the co-chairs will be implemented
Review of Joint Application Package	Currently under version JAP v4.0 with updates concerning new guidelines
Country-specific technical support for Joint Request for Selected PC Medicine and supply chain management	Approximately 40% of JRSM/countries' data is pre-populated annually by the ESPEN team. ESPEN has developed and implemented standard operating procedures (SOP). ESPEN conducted supply chain support missions in twelve African countries and hired consultants to enhance NTD management systems.
Complete delimitation/mapping gaps: onchocerciasis and schistosomiasis	Oncho elimination mapping (OEM) is being implemented progressively Schistosomiasis mapping gaps at district level were completed.
Support countries to take up Albendazole Alternative treatment for Loa and LF co-endemic	Chad, Congo Republic, DRC and South Sudan were supported by ESPEN to implement alternative treatment in LF and Loa co-endemic settings from 2019 to 2022.
Enhance the visibility of NTD Master Plans	NTD Master Plans disseminated through the ESPEN NTD Portal https://espen.afro.who.int/tools-resources/documents/country-ntd-master-plans

To WHO (2)

Recommendation	Action taken
Develop Onchocerciasis laboratory capacity in the region	ESPEN LAB, Benin, Burundi, Congo, Cameroon, DRC, Ghana, Mali, Mozambique, Nigeria, Sudan, Uganda, Tanzania, Togo, Senegal, received support from partners, including ESPEN, for training and/or supplies
Integrate the presentations for different Disease specific presentations and analysis	Disease specific presentations on the ESPEN Portal are now presented by Country, with provision for selecting for co-endemicity maps, and co-implementation maps.
Formalize the process of setting up the NTD elimination Sub Committees (Oncho/STH/Schisto) by end of April 2018	Disease sub-committees within the RPRG had already been established and convened once during an RPRG meeting but were not formalized with ToRs.
Review the format to present JAP and country summary reports	ESPEN Portal has been enhanced to include analytical dashboards, more maps and make data downloadable
Enhance resource mobilization	The project hired Speak Up Africa to mobilize resources, leading to successful donor engagement and the development of proposals, resulting in an increased funding portfolio of approximately $40 million to date

Session 2: Review and adoption of operational guidelines for the PC-NTD RPRG (*closed*)

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Review and adoption of SOPs, Modus Operandi, and TOR

PC-NTD RPRG Closed Session

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Health Break (20 min)

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Updates from Global NTD Programme

Dr Daniel Dagne

WHO - Geneva

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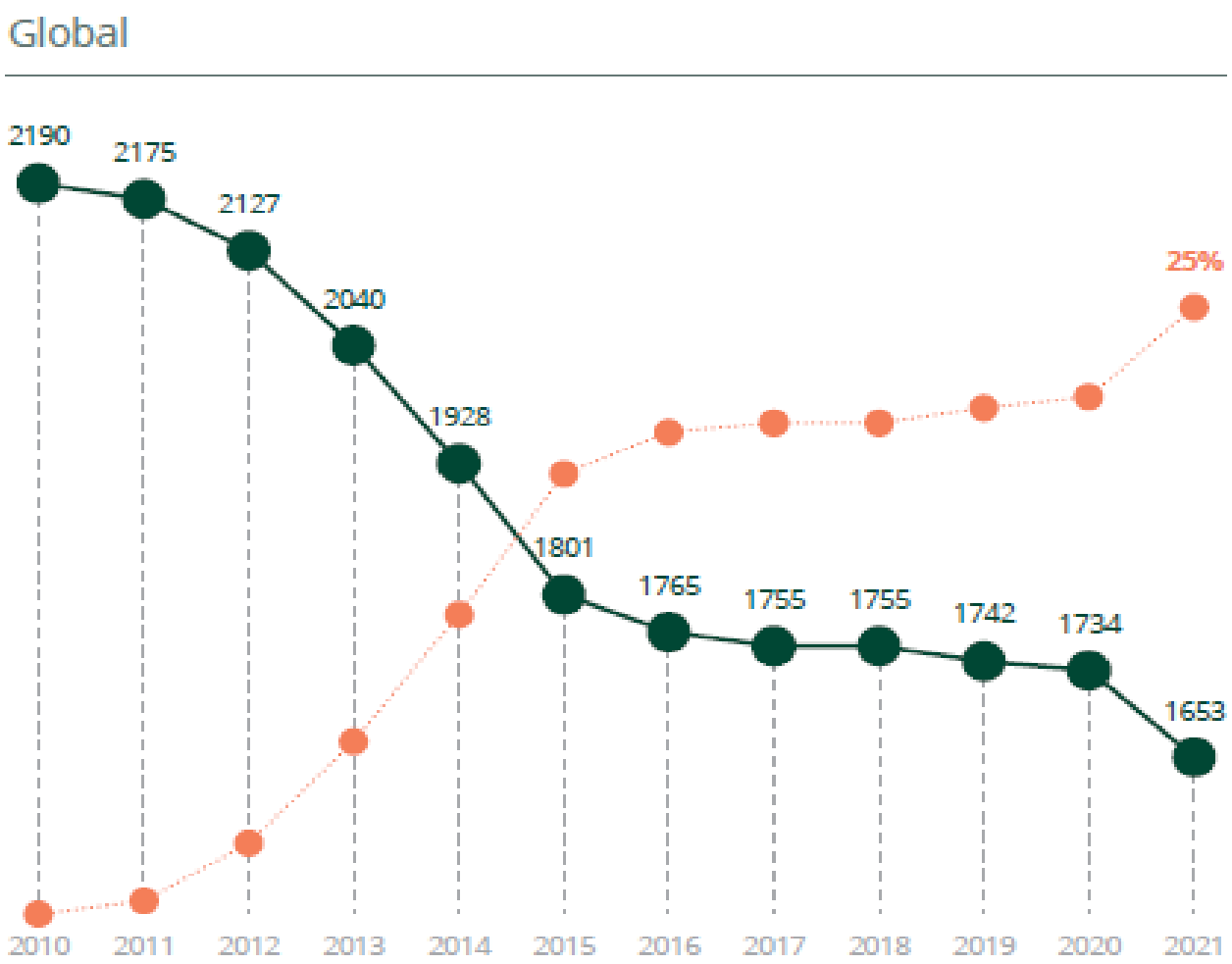
Fig. 1. Number of people requiring interventions against NTDs (green) and associated percentage reduction (orange) globally and regionally, 2010–2021



Road map overarching target 1 - SDG indicator 3.3.5: number of people requiring interventions against neglected tropical diseases

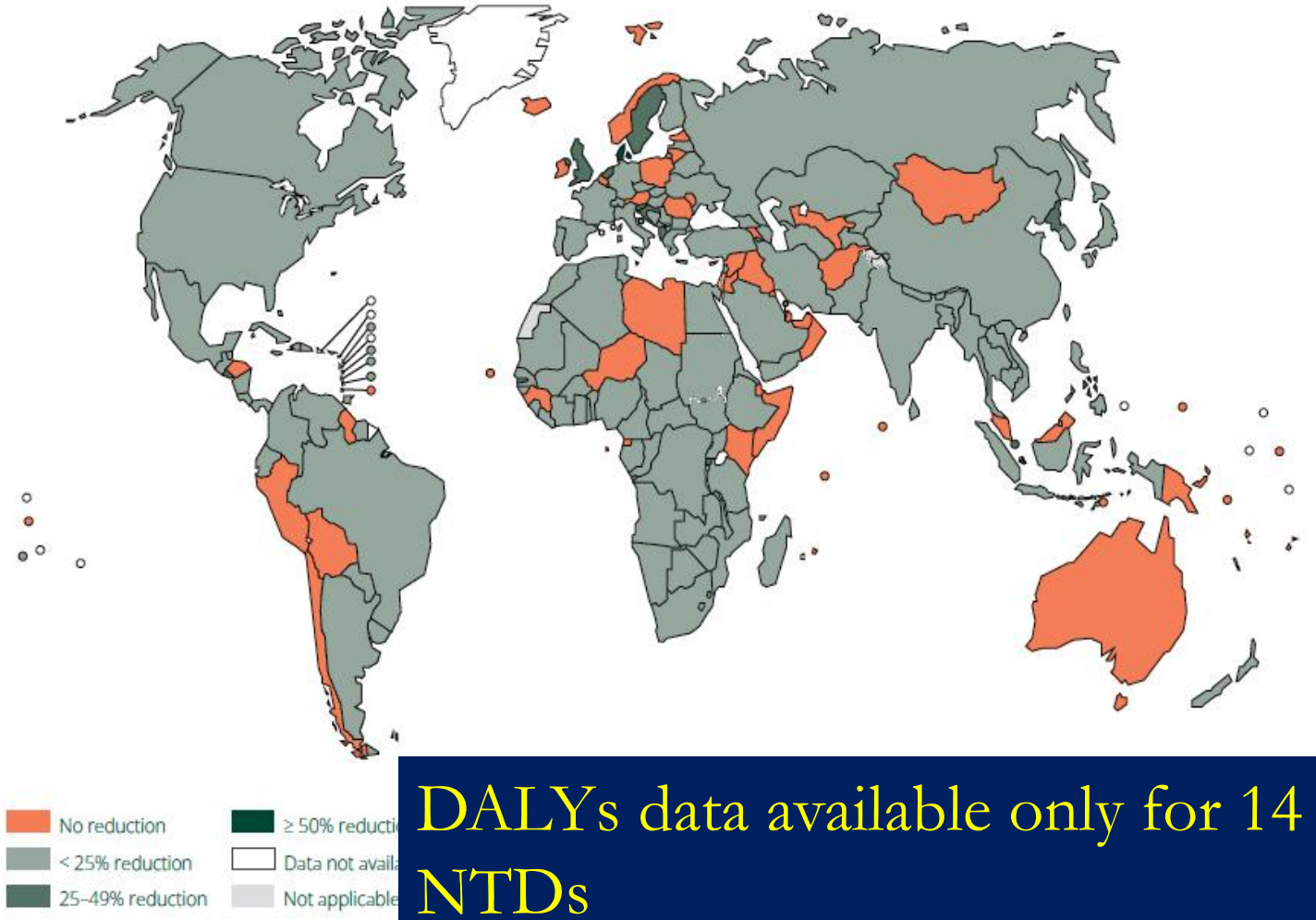
Achieved: -25% between 2010 and 2021
Target: -90% between 2010 and 2030

A decline of some 80 million people requiring NTD intervention occurred between 2020 and 2021 alone

Road map overarching target 2 – Reduce the burden of disease calculated in **DALYs related to NTDs by 75% from 2020**

- has gradually declined (-11% between 2015 and 2019) in the period preceding the launch of the road map

Fig. 4. Percentage reduction in DALYs related to NTDs, based on data available in 2019 versus 2015



DALYs data available only for 14 NTDs

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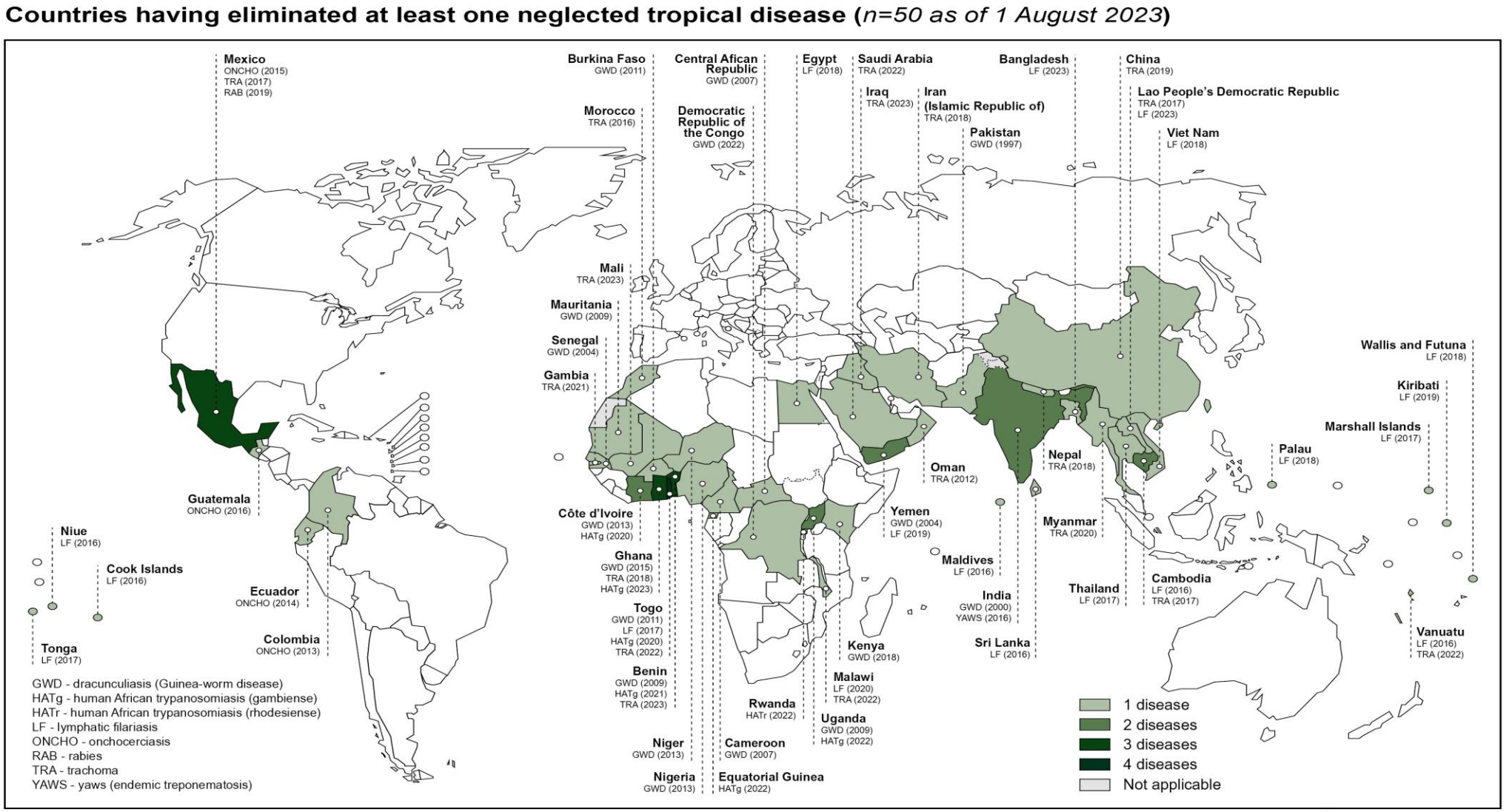
Road map overarching target 3:

Number of countries having eliminated at least one NTD

Target: 100 countries by 2030
Achieved: 50 countries



Data Source: World Health Organization
Map Production: Control of Neglected Tropical Diseases (NTD)
World Health Organization

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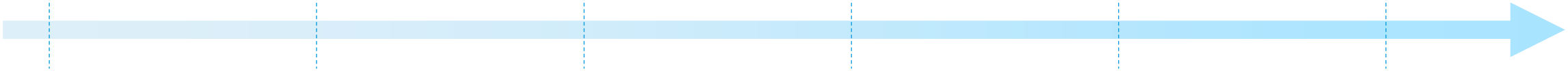
Road map overarching target 3:

Number of countries having eliminated at least one NTD

Countries that have completed validation, verification and certification processes for NTDs



2018	2019	2020	2021	2022	2023
Egypt (LF)	**China** (TRA)	**Côte d'Ivoire** (gHAT)	**Benin** (gHAT)	**DR Congo** (GWD)	**Bangladesh** (LF)
Ghana (TRA)	**Kiribati** (LF)	**Malawi** (LF)	**Gambia** (TRA)	**Eq. Guinea** (gHAT)	**Benin** (TRA)
IR of Iran (TRA)	**Mexico** (Rabies)	**Myanmar** (TRA)		**Malawi** (TRA)	**Ghana** (gHAT)
Kenya (GWD)	**Yemen** (LF)	**Togo** (gHAT)		**Rwanda** (rHAT)	**Iraq** (TRA)
Nepal (TRA)				**Saudi Arabia** (TRA)	**Lao PDR** (LF)
Palau (LF)				**Togo** (TRA)	**Mali** (TRA)
Vietnam (LF)				**Uganda** (gHAT)	
Wallis & Futuna (LF)				**Vanuatu** (TRA)	

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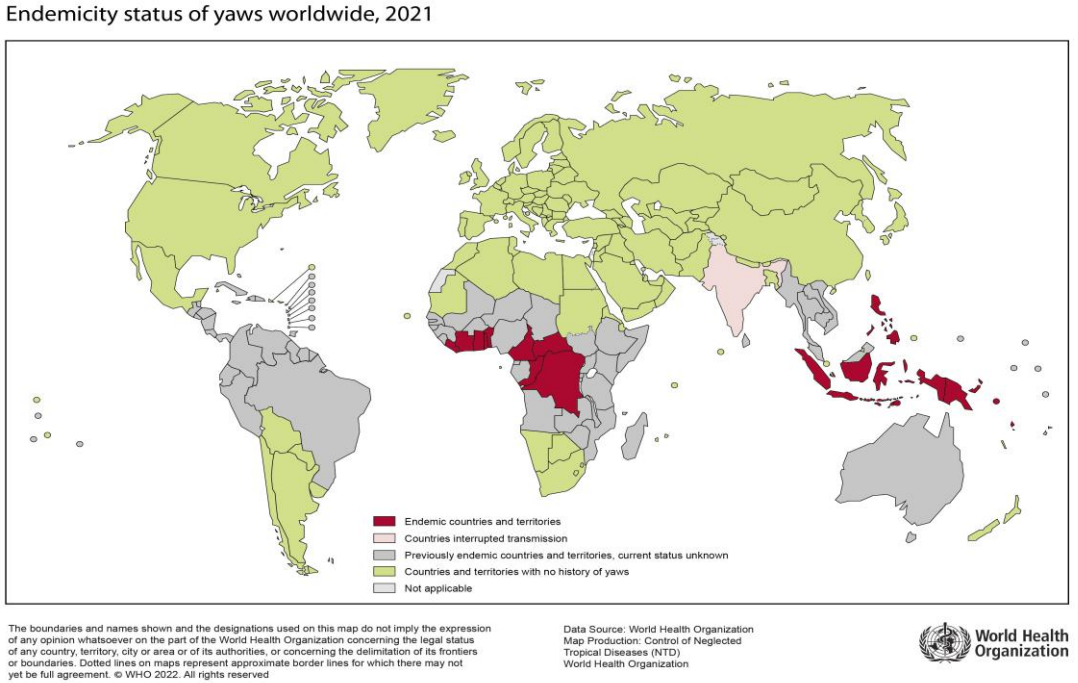
Road map overarching target 4:
Eradication of two NTDs

Dracunculiasis

- WHO has certified 200 countries, territories, and areas (belonging to 188 Member States)
- DRC certified in 2022.
- Only 13 cases of Guinea-worm disease in 2022
- 6 confirmed human cases reported in 2023 (Jan-Sept)

Yaws



- Intensified surveillance, capacity strengthening and MDA for yaws in several countries in WHO's African, American, South-East Asia and Western Pacific regions.
- 168,239 suspected cases in 2022. 14-15 countries with active transmission of yaws.

PROGRESS ON THE THREE PILLARS OF THE NTD ROAD MAP

Accelerate programmatic actions

- Technical progress
- Strategy & service delivery
- Enablers

Intensify cross-cutting approaches

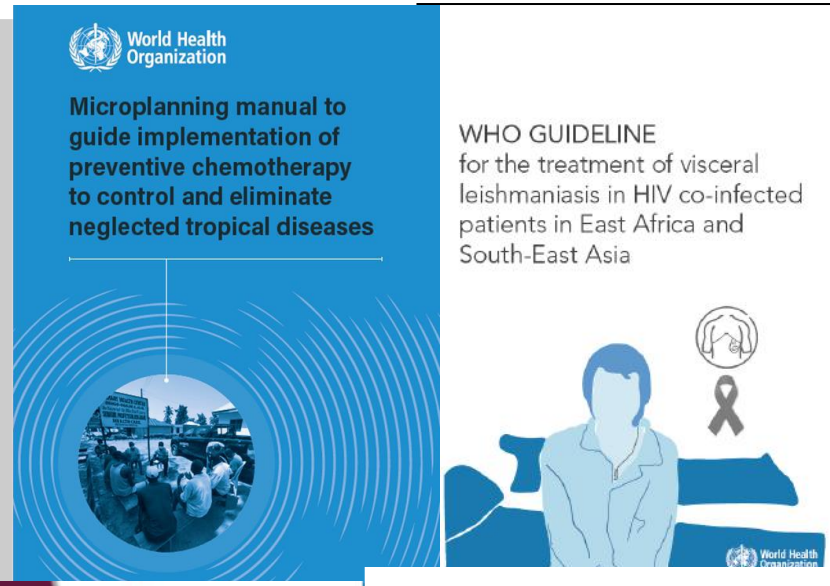
- Integrating
- Mainstreaming
- Coordinating

Change operating models and culture to facilitate country ownership

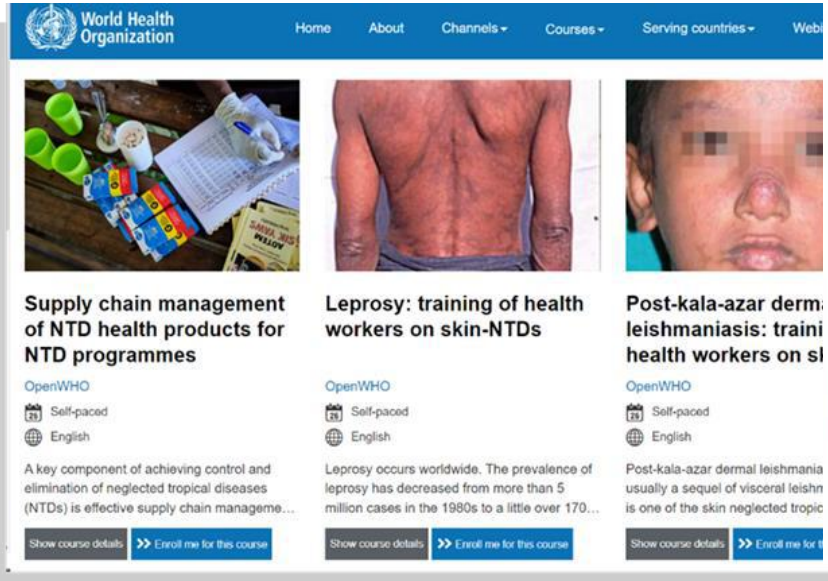
- Country ownership
- Clear stakeholder roles
- Organizational restructuring

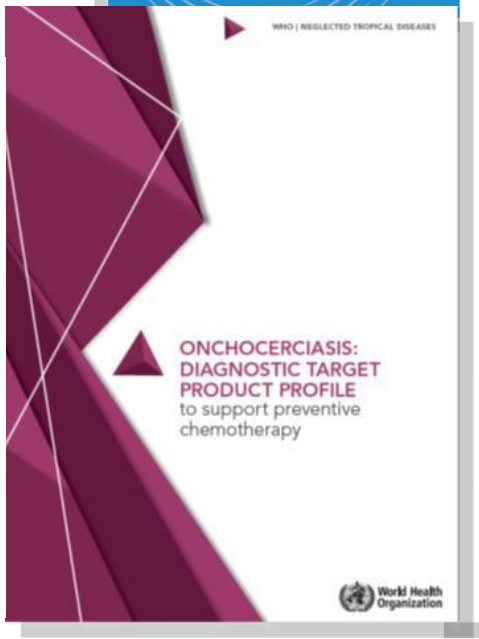
Pillar 1: Accelerating programmatic action (1)

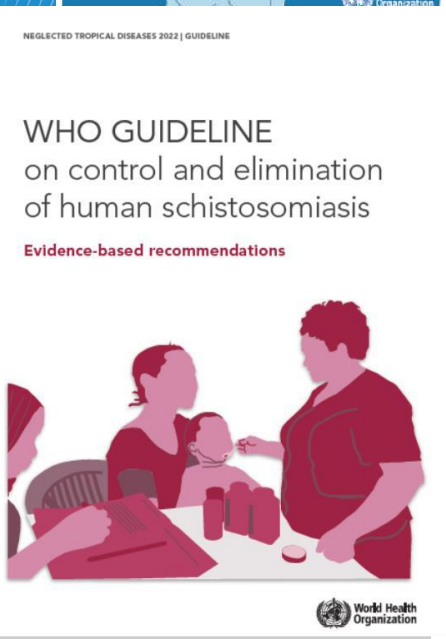
- **Normative guidance and tools:** 54 global WHO publications in 2021, 52 in 2022, 16 so far in 2023
- **Global advocacy:** WHA's endorsement of World NTD Day on 30 January (2021); adoption of the **Abu Dhabi Declaration on the Eradication of Guinea Worm** Disease and the **Kigali Declaration on Neglected Tropical Diseases (2022**)
- **Capacity building:** launch of an NTD channel on OpenWHO (2021), offering 47 multilingual courses on 23 different subjects – over 100 000 enrolled learners

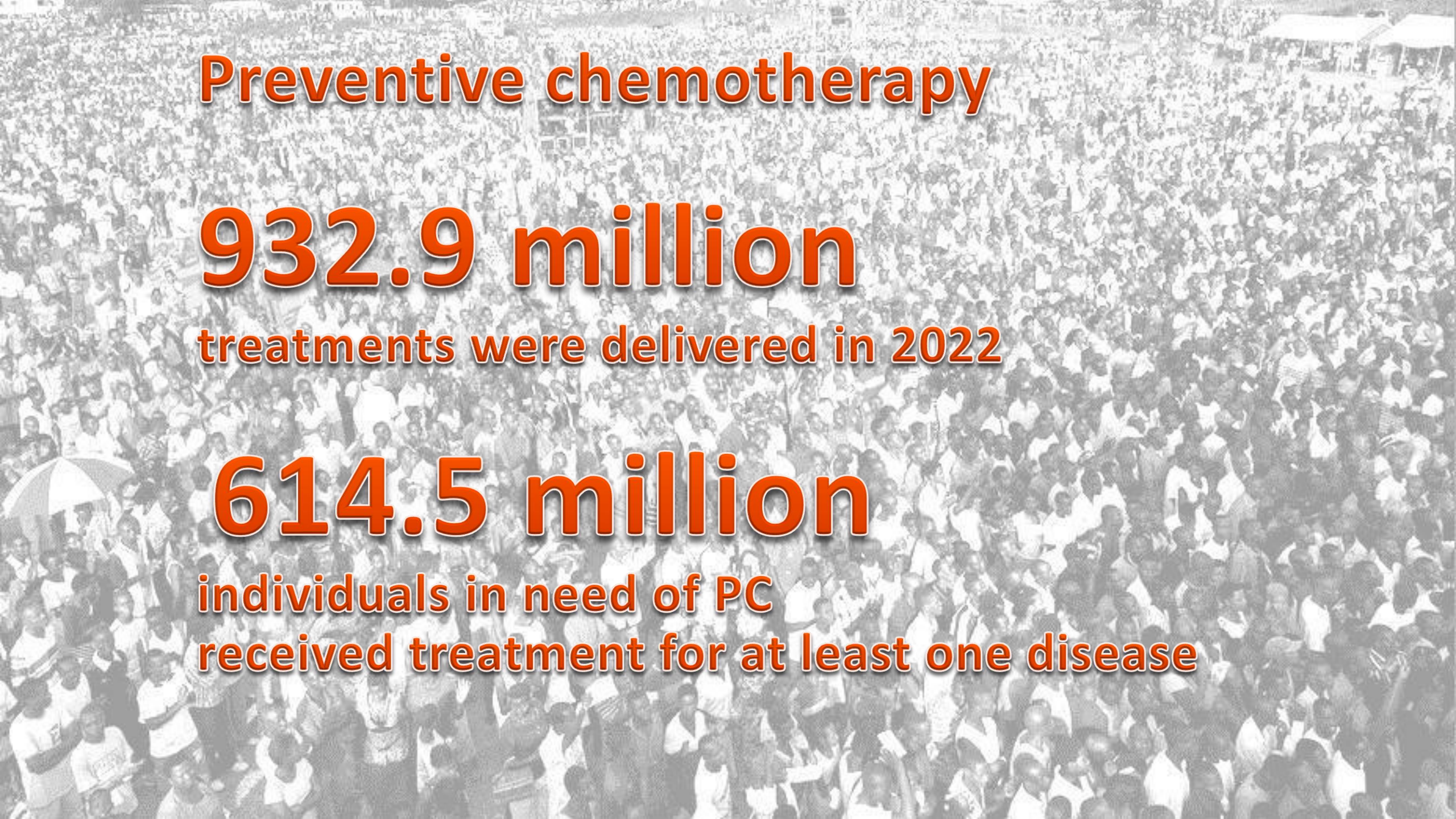


OpenWHO.org

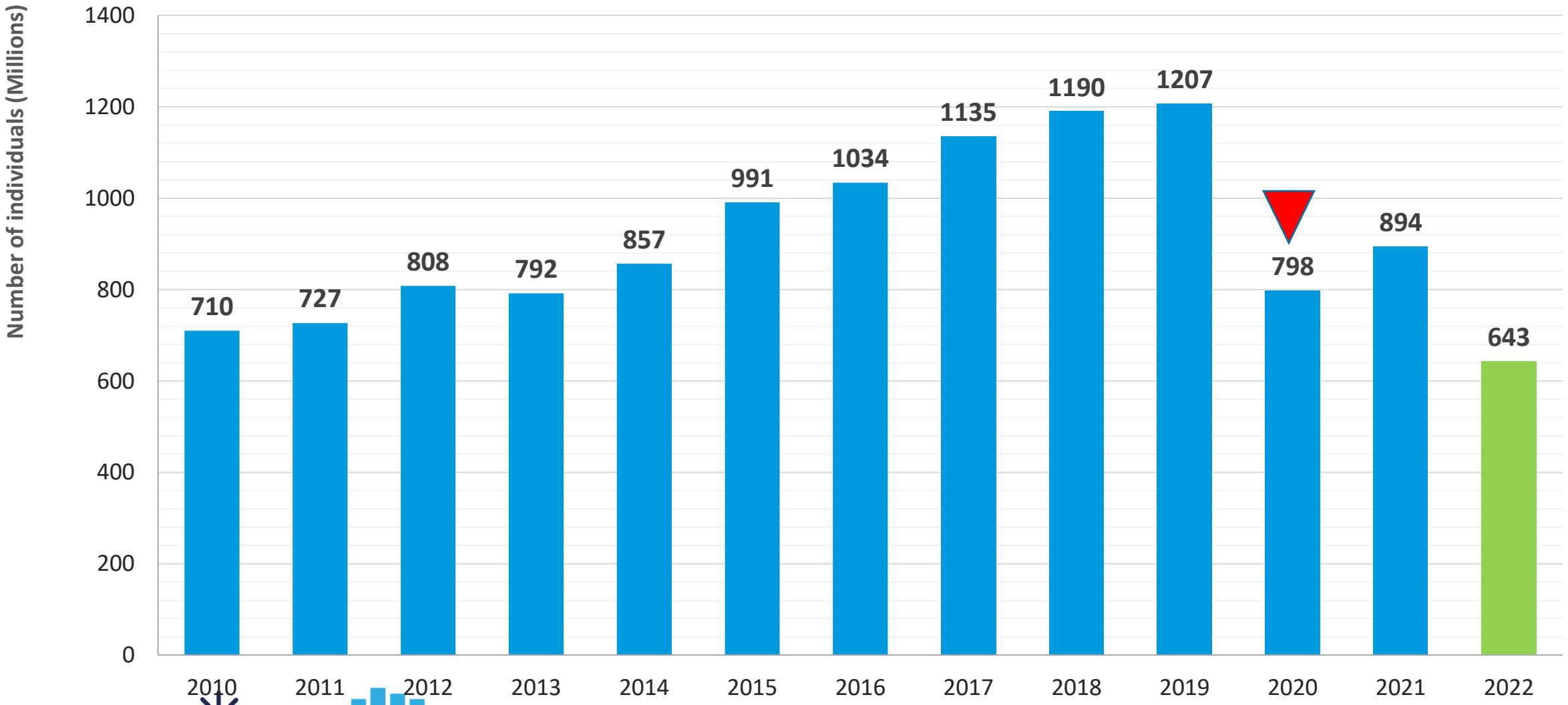







Preventive chemotherapy
932.9 million
treatments were delivered in 2022
614.5 million
individuals in need of PC
received treatment for at least one disease

Number of individuals received Preventive Chemotherapy (PC) interventions for at least one disease, 2010-2022 (as of 25 October 2023)



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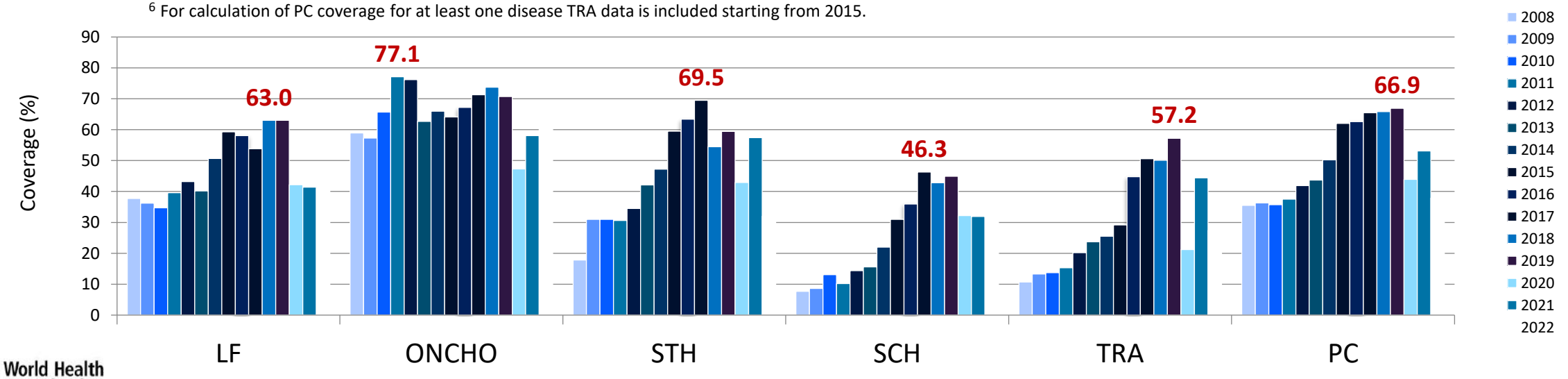
These interventions have been delivered to individuals living in areas which require PC and also in areas which may not require PC

Global status of preventive chemotherapy in 2022 (as of 25 October 2023)

PC implementation	LF	ONCHO	STH		SCH		TRA	PC[6]
			PreSAC	SAC	SAC	Adults		
Number of countries requiring PC[1]	44	29	86		50		31	101
Number of people requiring PC	794M	246.2M	254.5M	647.2M	134.9M	129.4M	132M	1623M
Number of countries implemented and reported	32	26	24	50	33	24	21	71
Proportion (%) of districts implemented PC[2]	65.4	76.1	22.2	69.9	37.4	13.0	25.9	ND
Proportion (%) of districts achieving effective coverage[3]	86.8	90.5	67.4	69.0	74.6	39.7	81.0	ND
Number of people in need treated[4]	325.7M	160.6M	43.6M	244.5M	68.6M	20.5M	36.2M	614.5M
Coverage (%)[5]	**41.0**	**65.3**	**17.1**	**37.8**	**50.9**	**15.8**	**27.4**	**37.9**

[1] Number of endemic countries moved to post-treatment surveillance stage is not included in total.
[2] Proportion of known endemic districts implementing PC in countries that reported on PC interventions.
[3] Proportion of districts implementing PC achieving the defined effective coverage for the disease ≥65% for LF and ONCHO, ≥75% for STH and SCH, and ≥80% for TRA.
[4] Number of people received treatment in areas where PC is required according to the recommended strategy for a specific disease.
[5] Coverage is calculated as the number of people treated out of total population requiring PC.
[6] For calculation of PC coverage for at least one disease TRA data is included starting from 2015.



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Source: WHO/NTD

LF – lymphatic filariasis; ONCHO – onchocerciasis; STH – soil-transmitted helminthiases; SCH – schistosomiasis; TRA – trachoma
PreSAC – preschool-aged children (1–4 years); SAC – school-aged children (5–14 years); Adults – people aged ≥15 years

Intensified disease management

- Disruptions to implementation of active and passive case-finding caused a decrease in the number of people detected, screened and managed for several case management NTDs

	BU	gHAT	rHAT	CL	VL	LEP	Rabies	Yaws	Echino	Dengue	GWD	TRA TT	Total
2019	2271	876	116	280 789	14 592	202 166	1120	98 162	5777	5 014 073	54	92 622	**5 712 618**
2020	1458	565	98	217 848	12 785	128 375	404	106 911	3589	2 733 216	27	42 045	**3 247 321**
2021	1661	747	55	221 790	11 767	140 546	66	123 866	2763	1 681 169	15	69 226	**2 031 881**
2022		799	38								13	129 224	

Source: GHO; BU: Buruli ulcer; gHAT: gambiense human African trypanosomiasis; rHAT: rhodesiense human African trypanosomiasis; CL: cutaneous leishmaniasis; VL: visceral leishmaniasis; LEP: leprosy; Echino: echinococcosis; GWD: Guinea-worm disease (dracunculiasis); TRA TT: trachoma (trachomatous trichiasis)

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Pillar 2: Intensifying cross-cutting approaches

Preventive chemotherapy programmes are being expanded to other diseases, such as taeniasis

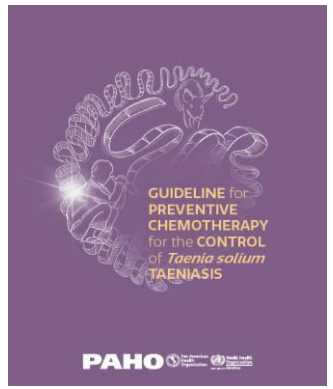
The integrated **skin-NTD approach** is being rolled out as an effective tool for reducing the burden of at least 10 diseases

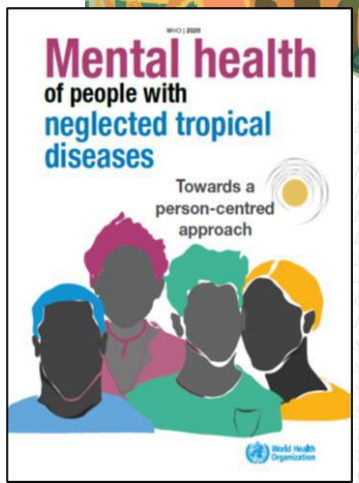
Intersectoral coordination is advancing on the **One Health** approach and on water, sanitation, and hygiene (**WASH**)

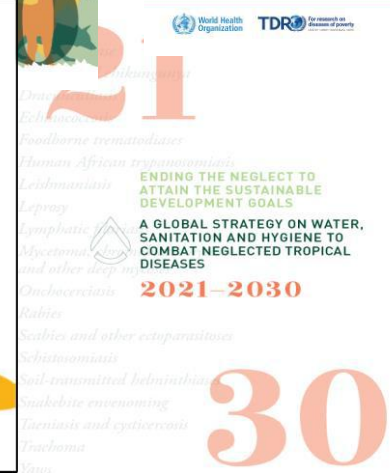
Coordination on vector control has been strengthened with the launch of the **Global Arbovirus Initiative**

Strengthening the **NTD M&E framework** with the aim of:

- ensuring that we report on all road map indicators and on all 20 diseases
- improving data visualization and accessibility through interactive dashboards
- facilitating integration and mainstreaming of NTD data into national HISs







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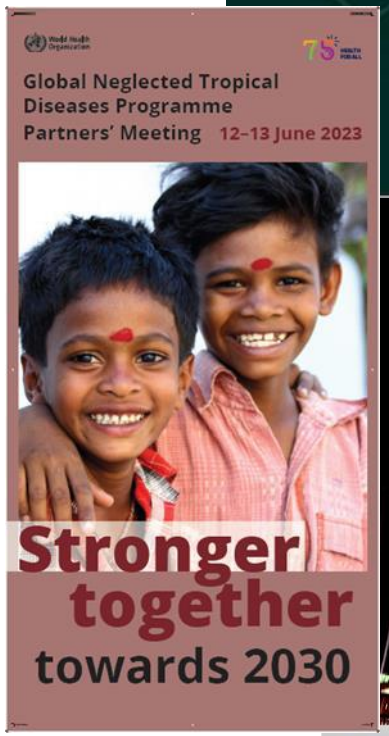
Pillar 3: Changing operating models and culture to facilitate country ownership

- Publication (2021) and promote use of the **WHO sustainability framework** in several countries
- Creation/expansion of global platforms/events to strengthen advocacy, information-sharing and coordination
- Inclusion of NTDs in UHC/PHC policy documents advancing comprehensive approaches and integrated service delivery
- Increased awareness that maintenance of essential services during health crises is a priority, and that sustainable funding is essential to achieving the goals set out in the road map



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Challenges

- Progress in controlling, eliminating, or eradicating NTDs has been hampered by:
  - Disruptions caused by the **COVID-19 pandemic**
  - Changing **funding landscape**
  - Slow & uneven progress in countries & across diseases
  - Programme disruptions & limited access to areas affected by **conflict, insecurity, political instability**
  - Underlying risk factors (poverty, climate change, migration, population displacement, etc.)

Credit: MSF

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Way forward

- Recover from the disruptions caused by COVID-19 and other challenges, and move further forward
- Fill normative gaps, expand our arsenal of medicines, diagnostics and tools, strengthen data collection, monitoring, reporting and evaluation
- Increase cohesiveness and efficiency by investing in strategies that foster integration and cross-sectoral collaboration
- Continue to facilitate country ownership and sustainability of NTD programmes through innovative policies and financing approaches
- Mainstreaming of NTDs in PHC/UHC, Health emergency, climate Health and other global relevant health initiatives

THANK YOU!

Thank you

For more information, please contact:

Dr Daniel Dagne
WHO-HQ/NTD/Coordinator PTC

daniel@who.int

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Introduction & Context

Dr Elizabeth Juma

ESPEN Team Lead

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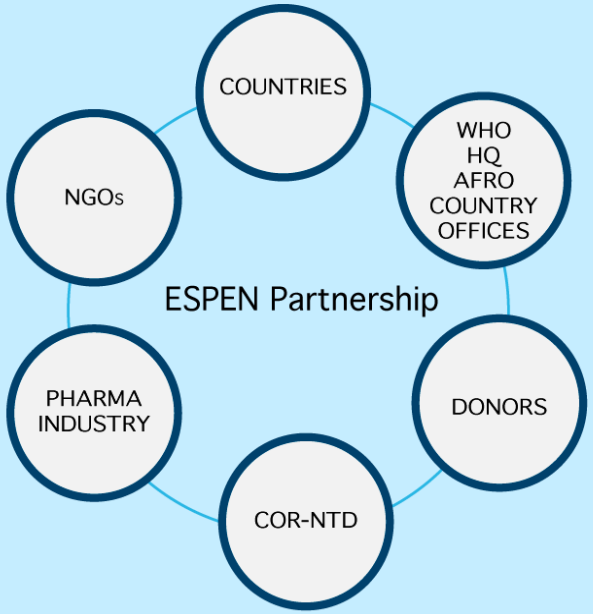
Outline

- Who is ESPEN
- What does ESPEN do?
- Where does ESPEN work?
- Operational Frameworks
- Governance Structure

ESPEN – Who we are

Private Public Partnership established in 2016 by WHO AFRO



Mission

Reduce burden of diseases in the WHO African Region through the Elimination of neglected tropical diseases amenable to preventive chemotherapy (PC-NTDs)

Strategic Priorities

1. **Scaling up**
   Scaling up MDA to achieve 100% geographic coverage and effective epidemiological coverage
2. **Scaling down**
   Scaling down MDA towards PC-NTD elimination and reduction of those at risk for NTDs
3. **Strengthening the information system**
   Strengthening the information management system for evidence-based implementation-level decision-making
4. **Effective use of medicines**
   Improving the effective use of donated medicines through enhanced supply chain management
5. **Partnership and coordination**
   Promote coordination, collaboration, country leadership, and partnerships

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ESPEN – Where we work

ESPEN covers 47 countries in the African Region

44/47* **countries** in the **region require preventive chemotherapy for NTDs**

** 45 out of 48 NTD programs*

Lymphatic filariasis

Onchocerciasis

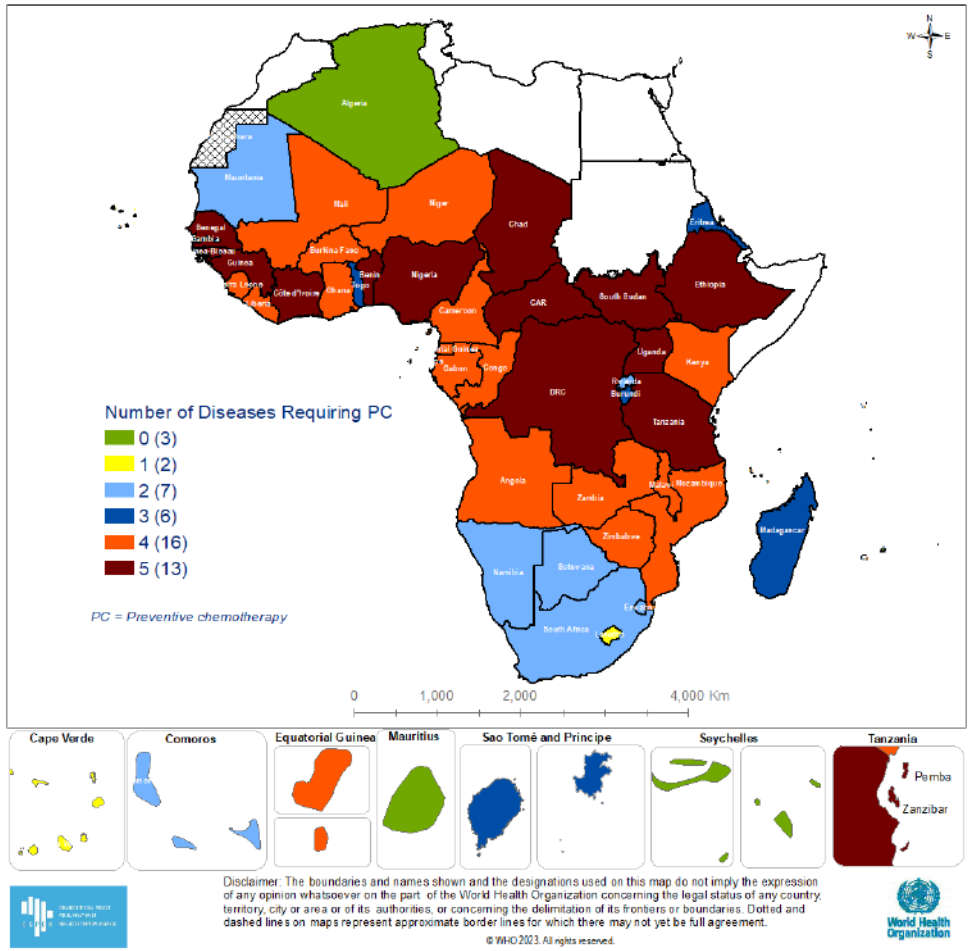
Schistosomiasis

Soil-transmitted helminthiasis

Trachoma

90% of NTD burden in Africa

60% of countries require PC for 4 or 5 PC-NTDs



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ESPEN – What we do

ESPEN collaborates directly with the Ministries of Health (MOH), stakeholders of National NTD programmes, and the NTD community to amplify the impact of NTD control and elimination initiatives

Fundraise approximately US$ 15M annually to provide technical and financial support to	• Achieve geographical coverage with interventions for disease control • Conduct population stratification and impact evaluation surveys
Support cross-cutting activities including capacity building, advocacy and monitoring and evaluation	• Collate strategic information for policy planning and decision making • Maintenance of a comprehensive data repository • Capacity building on data management, surveillance, monitoring and evaluation
Strengthen end-to-end supply chain management for medicines for neglected tropical diseases	• Facilitate of quantification of medicine requirements for MDA • Support logistic information management systems for reporting and accountability
Support strengthening of national and regional partnership coordination in the WHO Africa Region	• Facilitate development of national NTD master plans aligned with national, regional and global targets for disease elimination • Facilitate convening of national partner coordination mechanisms efficient and effective planning and implementation of interventions

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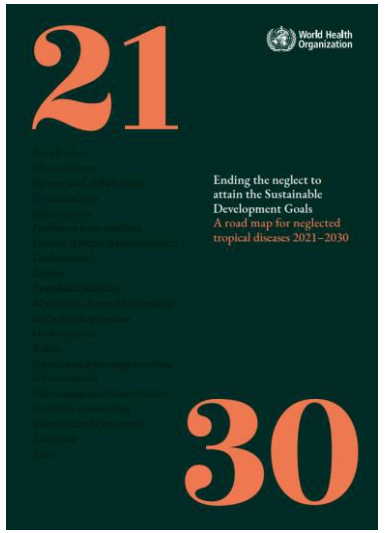
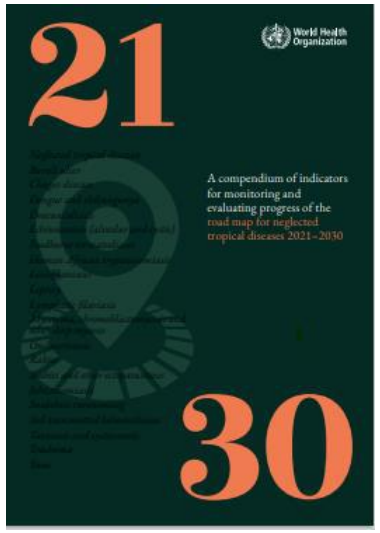
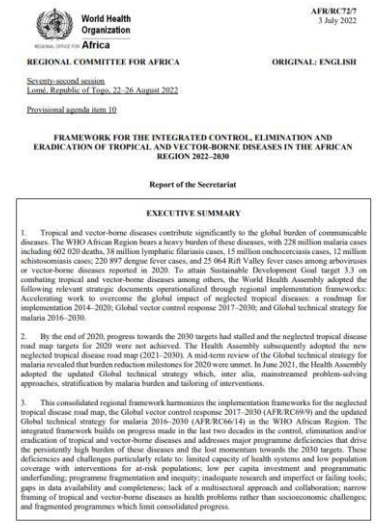
Operational context

Policy

- ESPENs work is guided by:
  - The *Ending the neglect to attain the Sustainable Development Goals: A road map for neglected tropical diseases 2021–2030* and its M&E framework
  - Framework for the integrated control, elimination and eradication of tropical and vector-borne diseases in the African Region 2022–2030
  - ESPEN Strategy Framework 2021 – 2025



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AFR/RC72/7
3 July 2022

REGIONAL COMMITTEE FOR AFRICA

ORIGINAL: ENGLISH

Seventy-second session
Lomé, Republic of Togo, 22–26 August 2022

Provisional agenda item 10

FRAMEWORK FOR THE INTEGRATED CONTROL, ELIMINATION AND ERADICATION OF TROPICAL AND VECTOR-BORNE DISEASES IN THE AFRICAN REGION 2022–2030

Report of the Secretariat

EXECUTIVE SUMMARY

1. Tropical and vector-borne diseases contribute significantly to the global burden of communicable diseases. The WHO African Region bears a heavy burden of these diseases, with 228 million malaria cases including 602 020 deaths, 38 million lymphatic filariasis cases, 15 million onchocerciasis cases, 12 million schistosomiasis cases; 220 897 dengue fever cases, and 25 064 Rift Valley fever cases among arboviruses or vector-borne diseases reported in 2020. To attain Sustainable Development Goal target 3.3 on combating tropical and vector-borne diseases among others, the World Health Assembly adopted the following relevant strategic documents operationalized through regional implementation frameworks: Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation 2014–2020; Global vector control response 2017–2030; and Global technical strategy for malaria 2016–2030.

2. By the end of 2020, progress towards the 2030 targets had stalled and the neglected tropical disease road map targets for 2020 were not achieved. The Health Assembly subsequently adopted the new neglected tropical disease road map (2021–2030). A mid-term review of the Global technical strategy for malaria revealed that burden reduction milestones for 2020 were unmet. In June 2021, the Health Assembly adopted the updated Global technical strategy which, inter alia, mainstreamed problem-solving approaches, stratification by malaria burden and tailoring of interventions.

3. This consolidated regional framework harmonizes the implementation frameworks for the neglected tropical disease road map, the Global vector control response 2017–2030 (AFR/RC69/9) and the updated Global technical strategy for malaria 2016–2030 (AFR/RC56/14) in the WHO African Region. The integrated framework builds on progress made in the last two decades in the control, elimination and/or eradication of tropical and vector-borne diseases and addresses major programme deficiencies that drive the persistently high burden of these diseases and the lost momentum towards the 2030 targets. These deficiencies and challenges particularly relate to: limited capacity of health systems and low population coverage with interventions for at-risk populations; low per capita investment and programmatic underfunding; programme fragmentation and inequity; inadequate research and imperfect or failing tools; gaps in data availability and completeness; lack of a multisectoral approach and collaboration; narrow framing of tropical and vector-borne diseases as health problems rather than socioeconomic challenges; and fragmented programmes which limit consolidated progress.

Programmatic

- Stagnation of progress on NTDs
  - Uncoordinated planning and implementation between PC-NTD programs and local partners
  - Inadequate geographical coverage
  - Inadequate resources for impact evaluation, and use of information for decision making
- Global financial crisis (sudden withdrawal of funding) reversing progress in some countries

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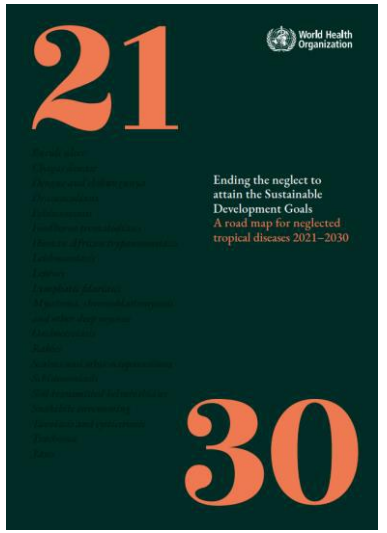
Operational context

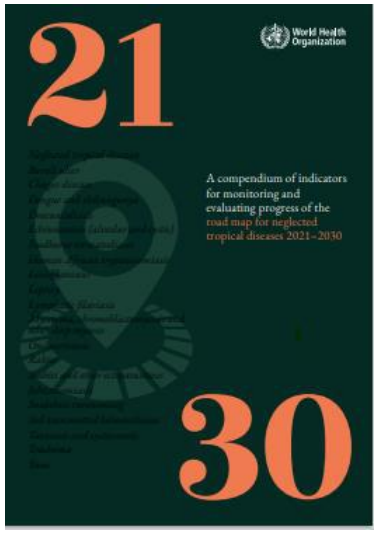
Environmental

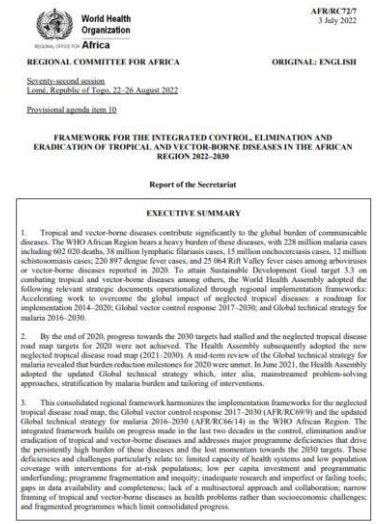
- Risks and effects worsening control efforts
  - Covid-19 Pandemic negatively impacted intervention implementation in 2020-2021
  - Climate change and natural disasters increase the risk of spread of NTDs

Political

- Humanitarian situations making planning and implementation of interventions impractical or unsafe
  - Internal and external conflict
  - Insecurity



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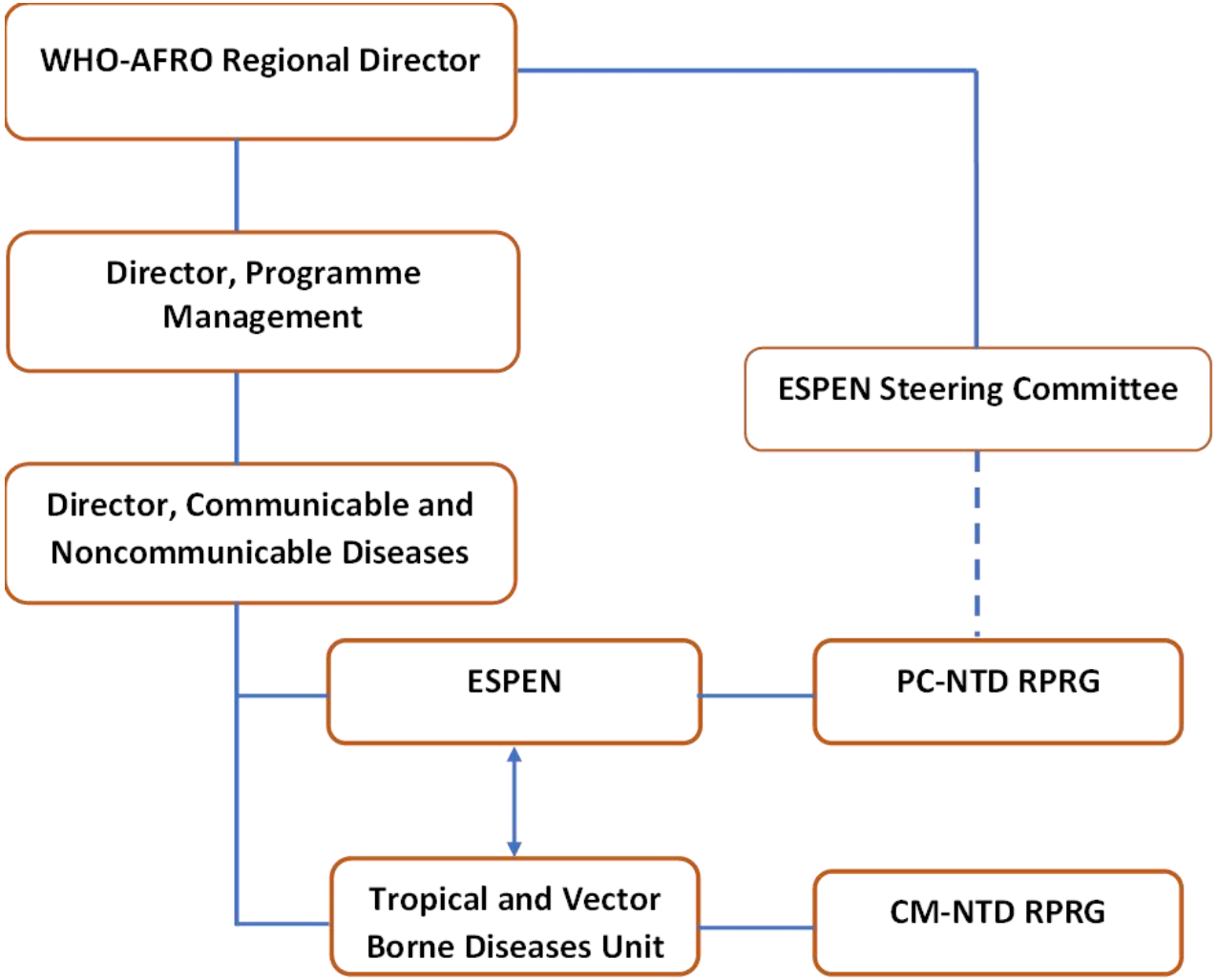
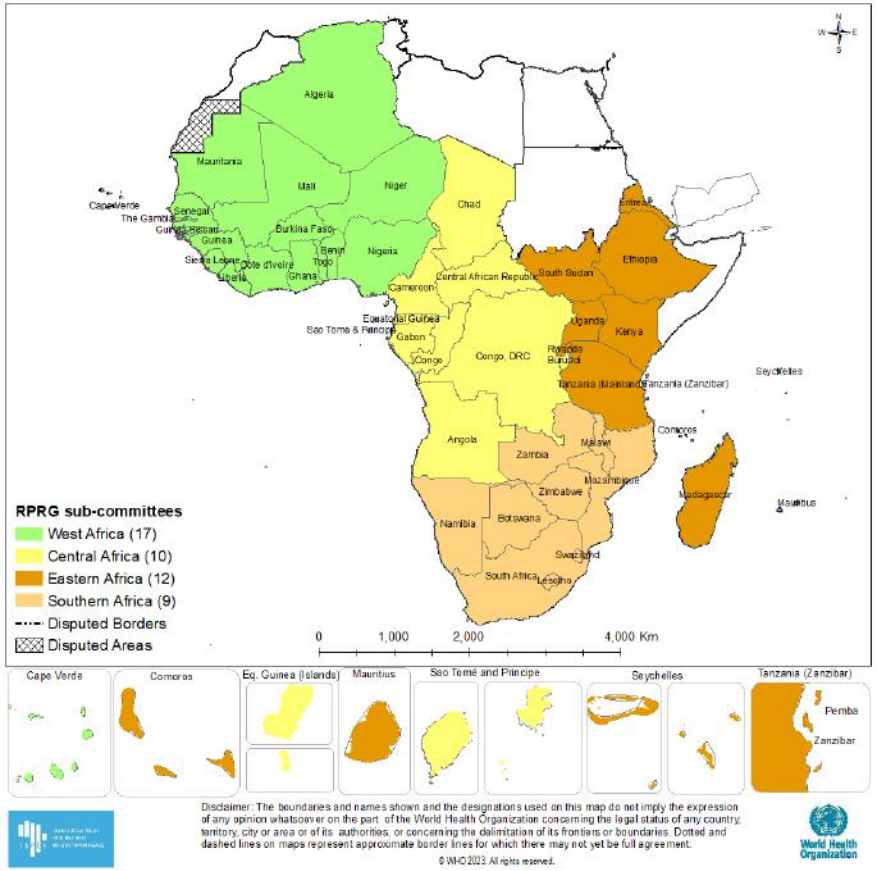
Governance Structure



ESPEN Regional Programme Review Group

ROLE

- To review progress towards regional and country goals and milestones and assess the overall adequacy of responsiveness to the regional policies and strategies of interventions required for achieving regional NTD programme targets and goals.
- To provide technical guidance to countries in order to accelerate the achievement of regional NTD programme targets and goals.
- To identify opportunities for operational research issues arising from the challenges on implementation of national programmes.
- To guide the national advocacy and domestic resource mobilization strategies to enhance national ownership and program sustainability.



- Each zone is represented by a sub-committee composed of 5 members (1 Chair, 4 members)
- Each group will meet once a year before the annual RPRG meeting
- Disease-specifc groups within the RPRG may be set up as needed, by the co-chairs

ESPEN Steering Committee

ROLE

- Provide strategic advice the Regional Director on reaching the Region's PC-NTDs control and elimination targets through specific recommendations to ESPEN
- More specifically, advises on:
  - ESPEN strategy for the attainment of regional targets for the elimination of NTDs
  - Resource mobilization to ensure adequate funding for the implementation of ESPEN's strategy, and the country work plans (including promoting domestic funding towards enhanced country ownership and sustainability).

REPRESENTATION

- 15 – 18 Members
  - **WHO** (Legal Officer, Director, ESPEN Team Lead)
  - **1st Constituency:** 8 AFRO Member states senior management level within the Ministry of Health such as Director of Communicable Diseases, Chief Medical Officer, and Permanent Secretary.
  - **2nd Constituency:** ESPEN Donors, 2-3 representatives
  - **3rd Constituency:** PC NTD medicine donors, 1-2 representatives
  - **4th Constituency:** PC-NTD implementing partners NNN (NTD NGO Network), 2 representatives
- The committee chair is elected among members for a period of 2 years

Achievements of the ESPEN partnership

- Lymphatic Filariasis
  - 2 countries certified for Elimination – *Malawi and Togo*
  - 7 countries have stopped MDA, conducting impact assessments -*Benin, Cameroon, Comoros, Eritrea, Mali, Sao Tome and Principe and Uganda*
- Soil Transmitted Helminthiases
  - 3 countries have reduced transmission below threshold for preventive chemotherapy - *Burkina Faso, Mali and Niger*
- Onchocerciasis
  - *Niger* has submitted elimination dossier
  - *Senegal* has stopped MDA for oncho in all endemic areas
  - *Uganda* has stopped MDA for more than 50% population requiring PC
  - *Equatorial Guinea*, *Ethiopia, and Nigeria* have stopped MDA in some foci
- Trachoma
  - 6 countries validated for elimination as public health problem: *Benin, Gambia, Ghana, Malawi, Mali, and Togo,*
  - 3 countries preparing dossiers or under review – *Botswana, Burundi and Mauritania*
- Schistosomiasis
  - Two countries have interrupted transmission pending impact evaluations – *Algeria and Mauritius*

Thank you

For more information, please contact:

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Session 3: Regional Disease Trends

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Updates on Trachoma in the WHO African Region

Dr Amir B Kello

Medical Officer Trachoma

World Health Organization African Region

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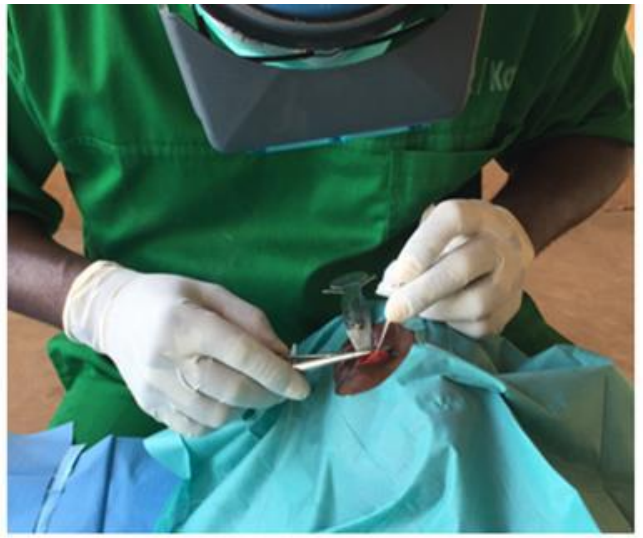
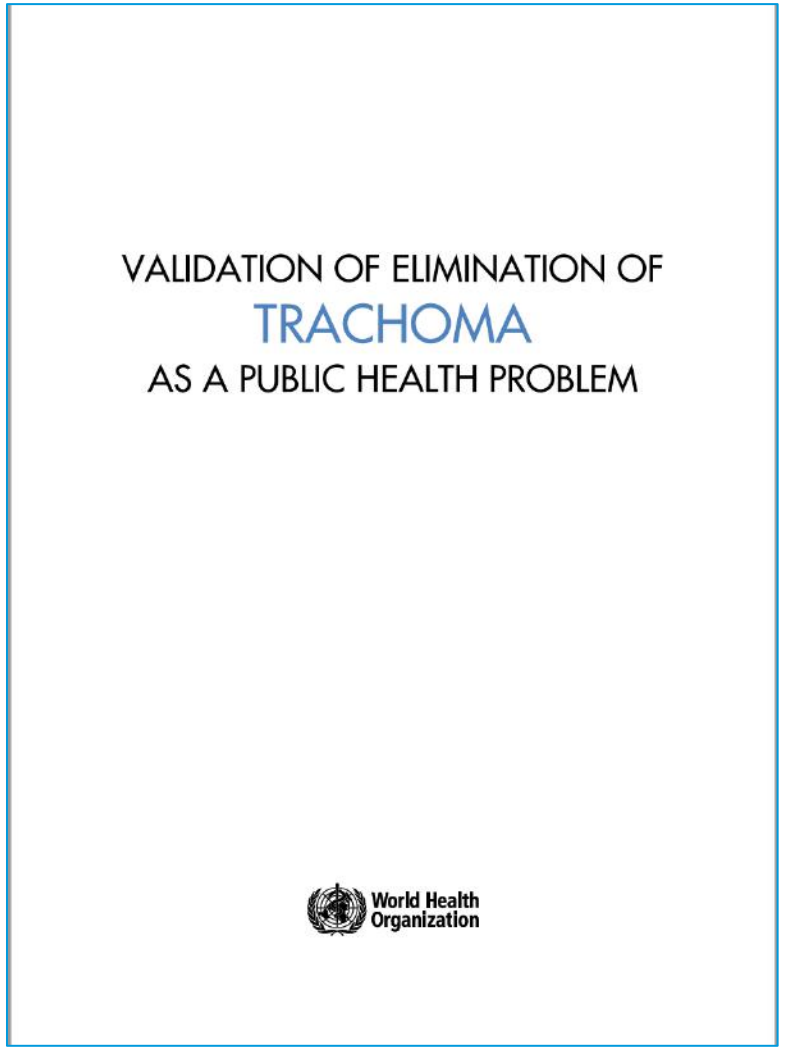
Trachoma – The SAFE Strategy

- **S**urgery to treat *Trachomatous trichiasis* (TT);
- **A**ntibiotics to clear infection;
- **F**acial cleanliness; and
- **E**nvironmental improvement, particularly improving access to water and sanitation to prevent transmission.



Elimination of Trachoma as a Public Health Problem

- Criteria for validation:
  i. A prevalence of trachomatous trichiasis (TT) “unknown to the health system” of < 0.2% in adults aged ≥15 years;
  ii. A prevalence of trachomatous inflammation—follicular (TF) in children aged 1–9 years of <5%, in each formerly endemic district;
  iii. Evidence that the health system can continue to identify and manage incident cases of TT.



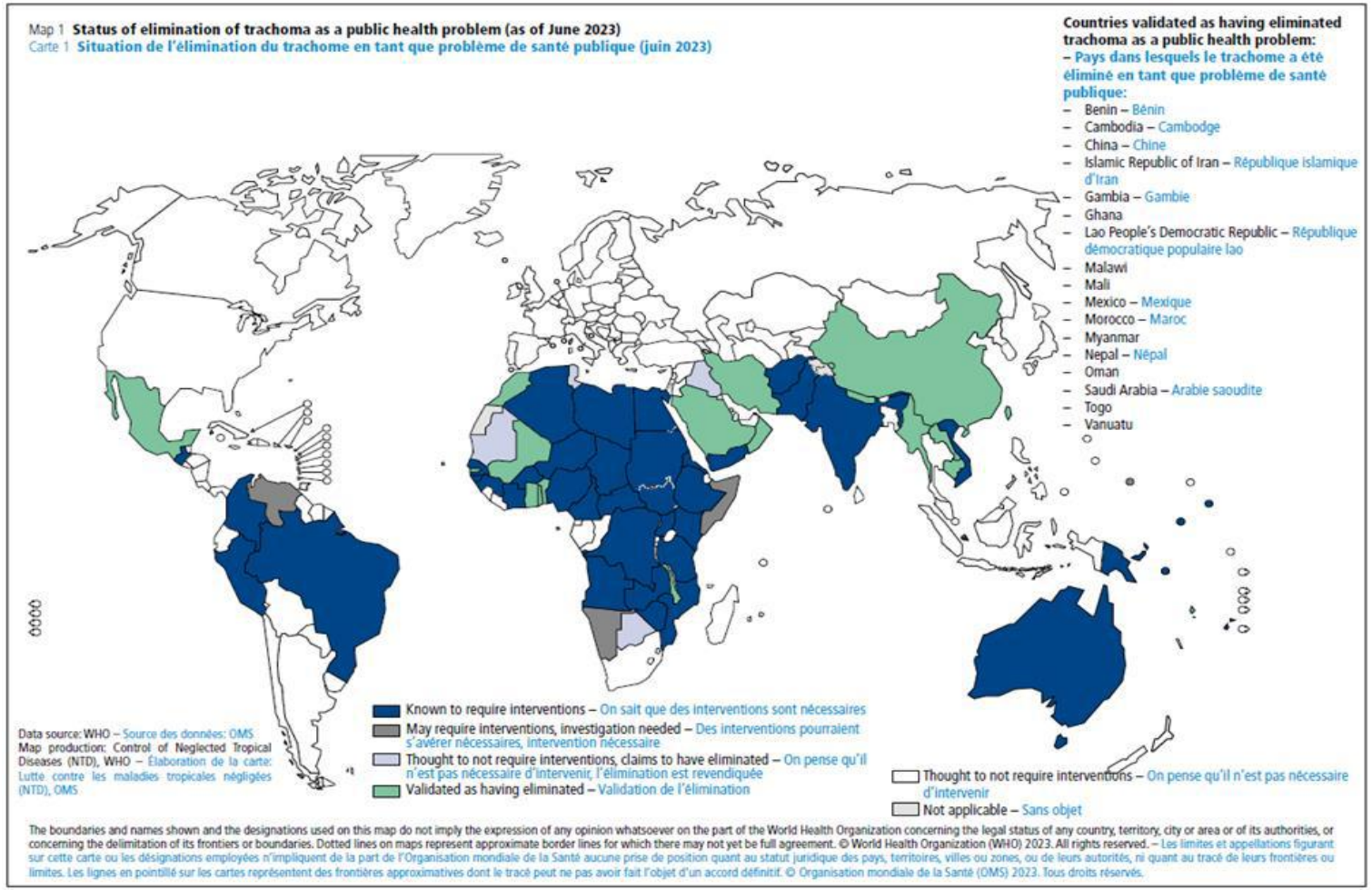
WHO 2030 Targets & Achievements for Trachoma

Indicator	Estimate 2020	Target 2023	Target 2025	Target 2030
Number of countries validated for elimination of trachoma APHP	10/66 (15%)	28/66 (42%)	43/66 (65%)	66/66 (100%)
		Achievement 18/28 (64%)		

Trachoma Burden – Global

- 40 countries endemic
- 115.7M live in at-risk areas
- TT burden 1.5M cases
- To date, 18 countries validated as having eliminated TRA as a PHP

Benin, Cambodia, China, Gambia, Ghana, Iraq, Islamic Republic of Iran, Lao People's Democratic Republic, Malawi, Mali, Mexico, Morocco, Myanmar, Nepal, Oman, Saudi Arabia, Togo and Vanuatu



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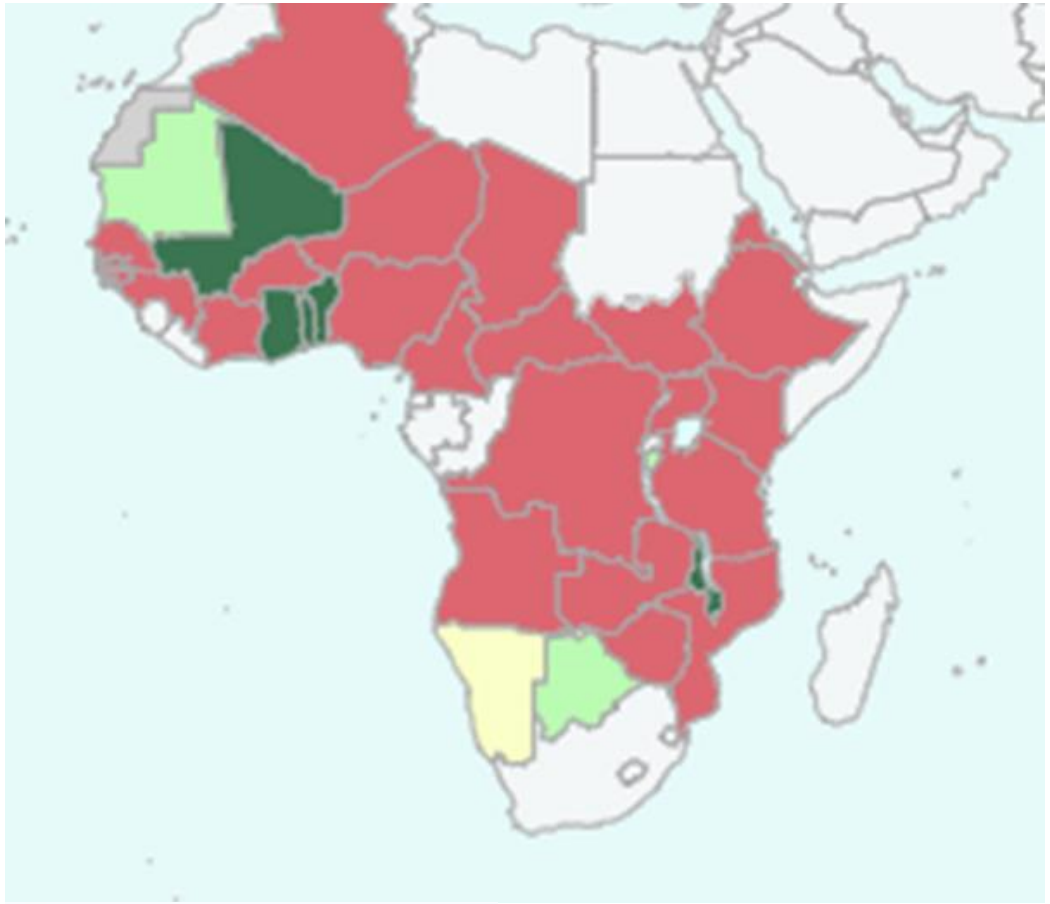
Trachoma Burden – WHO African Region

- 22 countries endemic
- 99.6M live in at risk areas
  - 86% of global burden
- 1.2M TT cases
  - 80% of global burden
- 6 countries validated
  - Ghana (June 2018), Gambia (April 2021), Togo (May 2022), Malawi (Sep 2022), Benin and Mali (May 2023)



https://apps.who.int/neglected_diseases/ntddata/trachoma/trachoma.html

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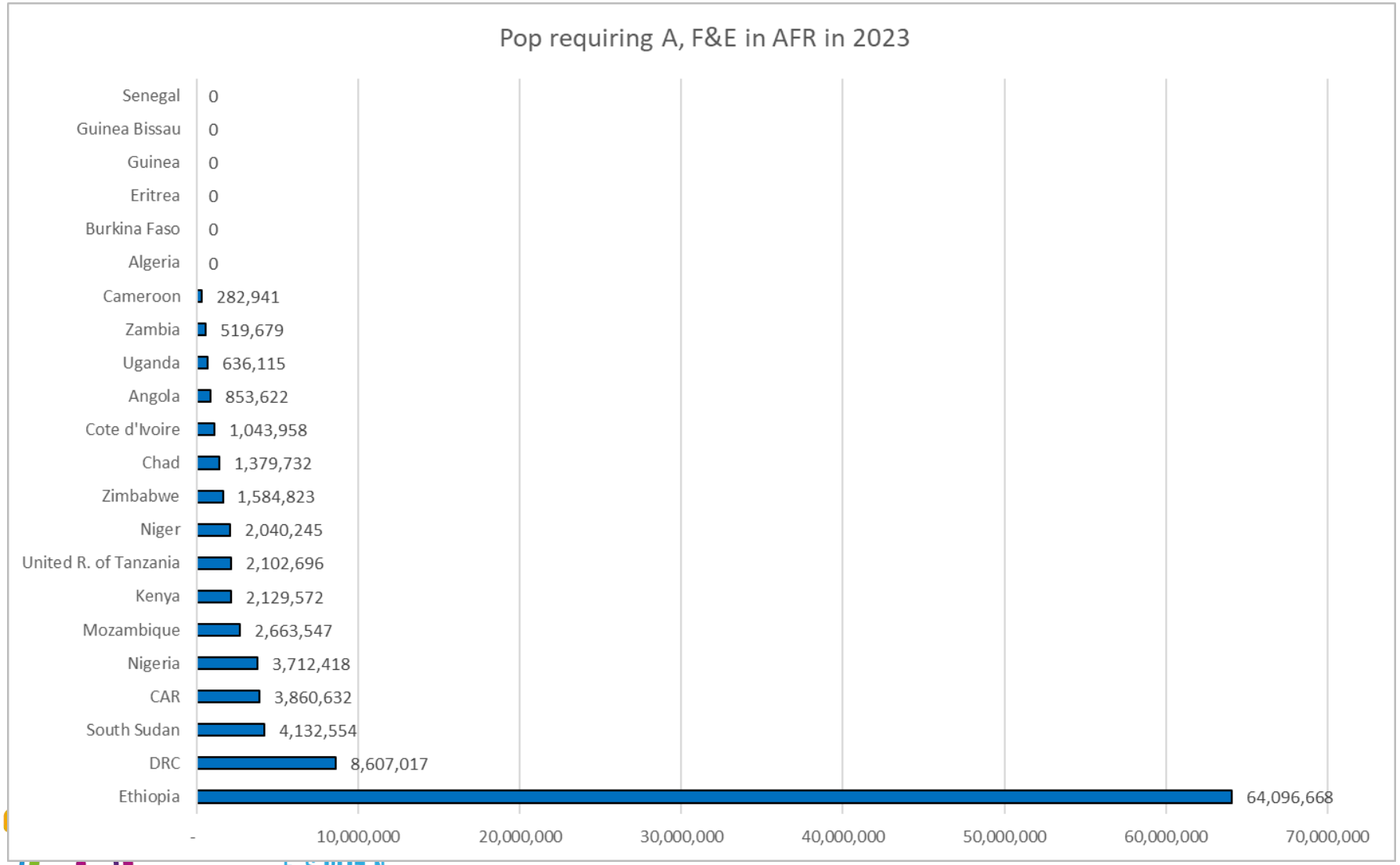
Population Requiring A, F&E in the AFR (Apr 2023)



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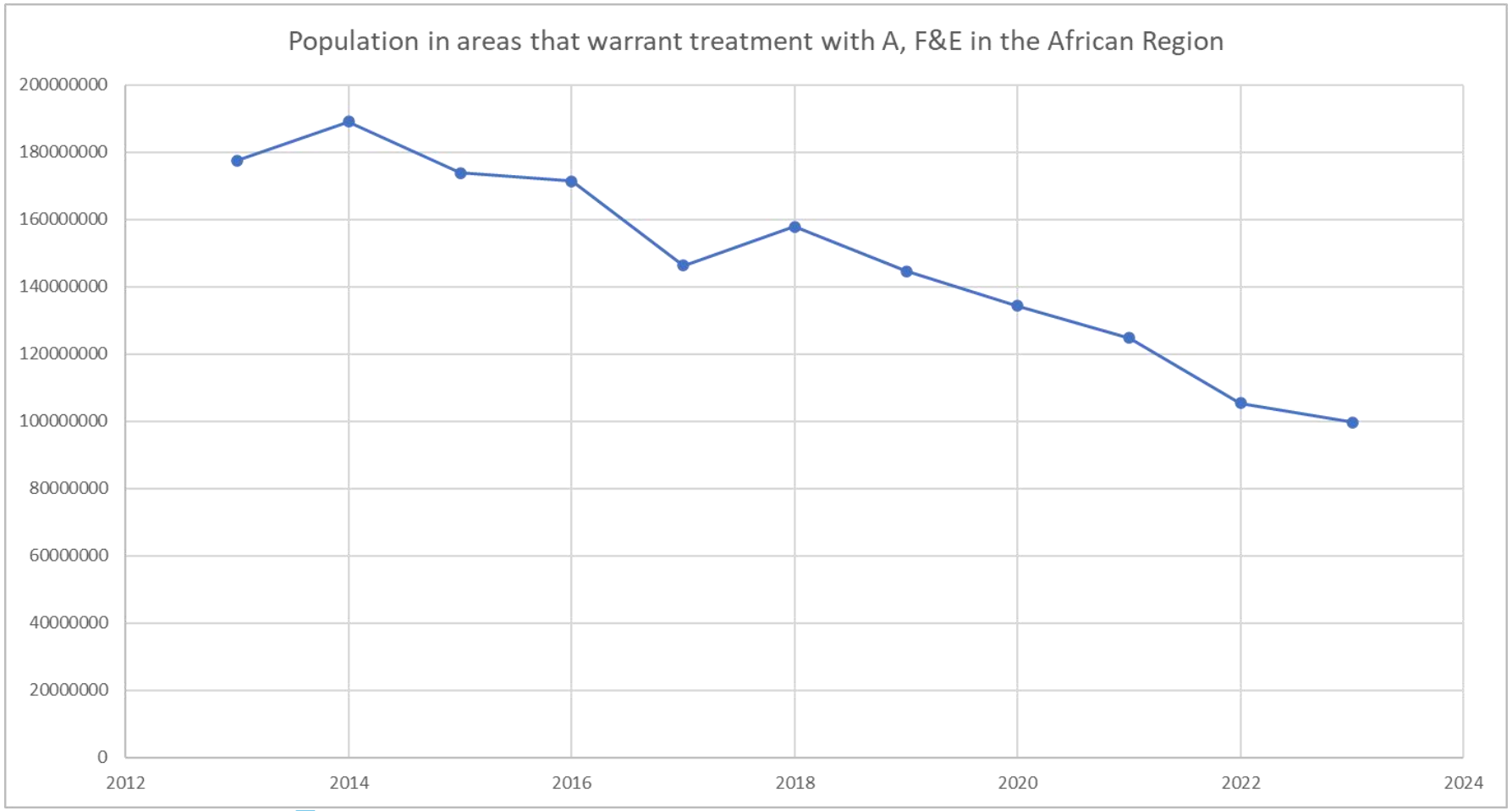
Population Living in at Risk Areas in the AFR (2013-2023)



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Status of Trachoma Elimination in the African Region

Countries thought not to require intervention

1. Cape Verde
2. Comoros
3. Equatorial Guinea
4. Eswatini
5. Gabon
6. Lesotho
7. Liberia
8. Madagascar
9. Mauritius
10. Republic of Congo
11. Rwanda
12. Sao Tome & Principe
13. Seychelles
14. Sierra Leone
15. South Africa

Countries that may require interventions; investigation needed

1. Namibia

Countries known to require intervention

1. Algeria
2. Angola
3. Burkina Faso
4. Cameroon
5. Central African Republic
6. Chad
7. Cote d'Ivoire
8. Democratic Republic of the Congo
9. Eritrea
10. Ethiopia
11. Guinea
12. Guinea-Bissau
13. Kenya
14. Mozambique
15. Niger
16. Nigeria
17. Senegal
18. South Sudan
19. United Rep. of Tanzania
20. Uganda
21. Zambia
22. Zimbabwe

Countries thought not to require interventions; claims to have eliminated

1. Botswana
2. Burundi
3. Mauritania

Validated to have eliminated trachoma as a PHP

1. Ghana
2. Gambia
3. Togo
4. Malawi
5. Benin
6. Mali

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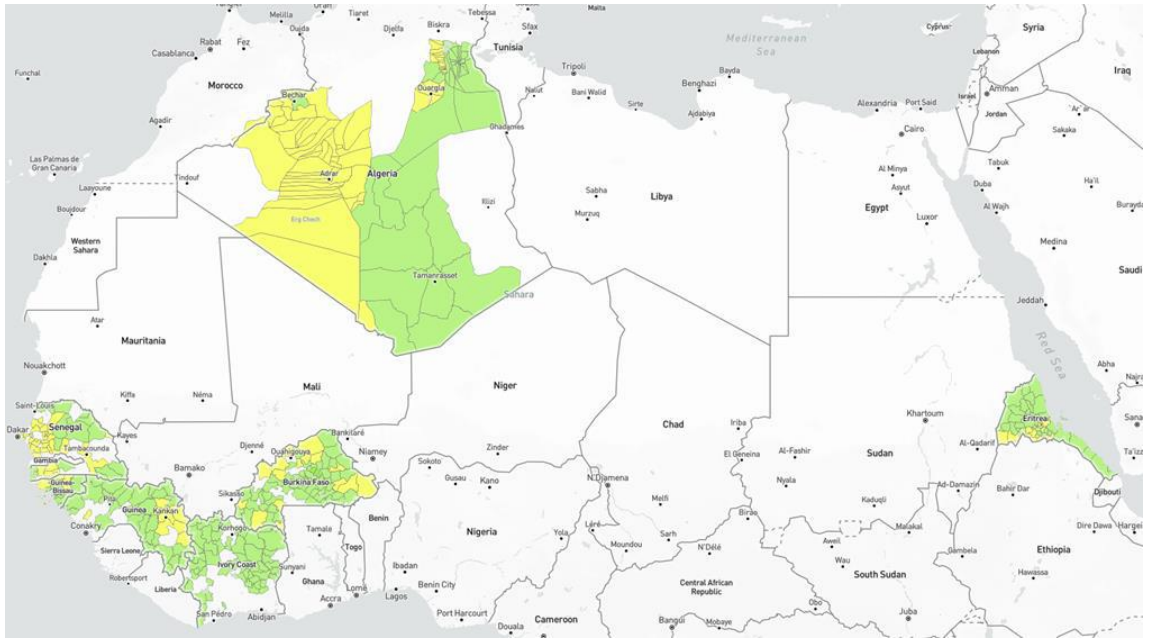
Challenges in the WHO African Region

- 7 countries have achieved elimination threshold for TF but have yet to reach the TT elimination threshold
    1. Algeria
    2. Burkina Faso
    3. Cote d'Ivoire
    4. Eritrea
    5. Guinea
    6. Guinea Bissau
    7. Senegal



Persistent & Recrudescent Trachoma in AFR (June 2023)

Persistent Districts

Country	Districts ever endemic	Number of persistent districts	Total population living in persistent districts
Ethiopia	815	194	23,357,377
Kenya	33	4	787,021
Mozambique	71	7	1,002,083
Niger	99	5	978,755
Nigeria	127	6	910,253
South Sudan	37	3	308,999
Tanzania	77	5	882,934
Uganda	57	1	126,300
Zambia	46	3	313,787
Total	**1,362**	**228**	**28,667,509**

Recrudescent Districts

Country	Districts ever endemic	Number of recrudescent districts	Total population living in recrudescent districts
Cameroon	24	3	251,931
Chad	44	4	380,893
Ethiopia	815	70	8,579,737
Kenya	33	3	355,294
Mozambique	71	3	605,136
Niger	99	6	1,265,725
Tanzania	77	5	1,044,001
Uganda	57	4	567,146
Total	**1,220**	**98**	**13,049,863**

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Recommendations to Address Persistent & Recrudescent Districts

- WHO informal consultation of trachoma end game challenges (Dec 2021)
  - Definition of persistent & recrudescent districts
  - Bespoke management of each EU guided by expert opinion based on evidence
- TEC decisions
  - Prioritizing Zx provision to districts that need MFTA MDA

Priorities in the WHO African Region

- Reaching 100% geographic coverage for MDA and TT surgery
- Addressing persistent and recrudescent districts
- Reaching special populations & “insecure” areas
- Cross-border collaborations
- Supporting countries with TRA elimination dossiers
- Post-validation surveillance

Thank you

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Overview of Schistosomiasis Progress in the WHO African region

Dr Pauline Mwinzi

Technical Officer SCH/STH

World Health Organization African Region

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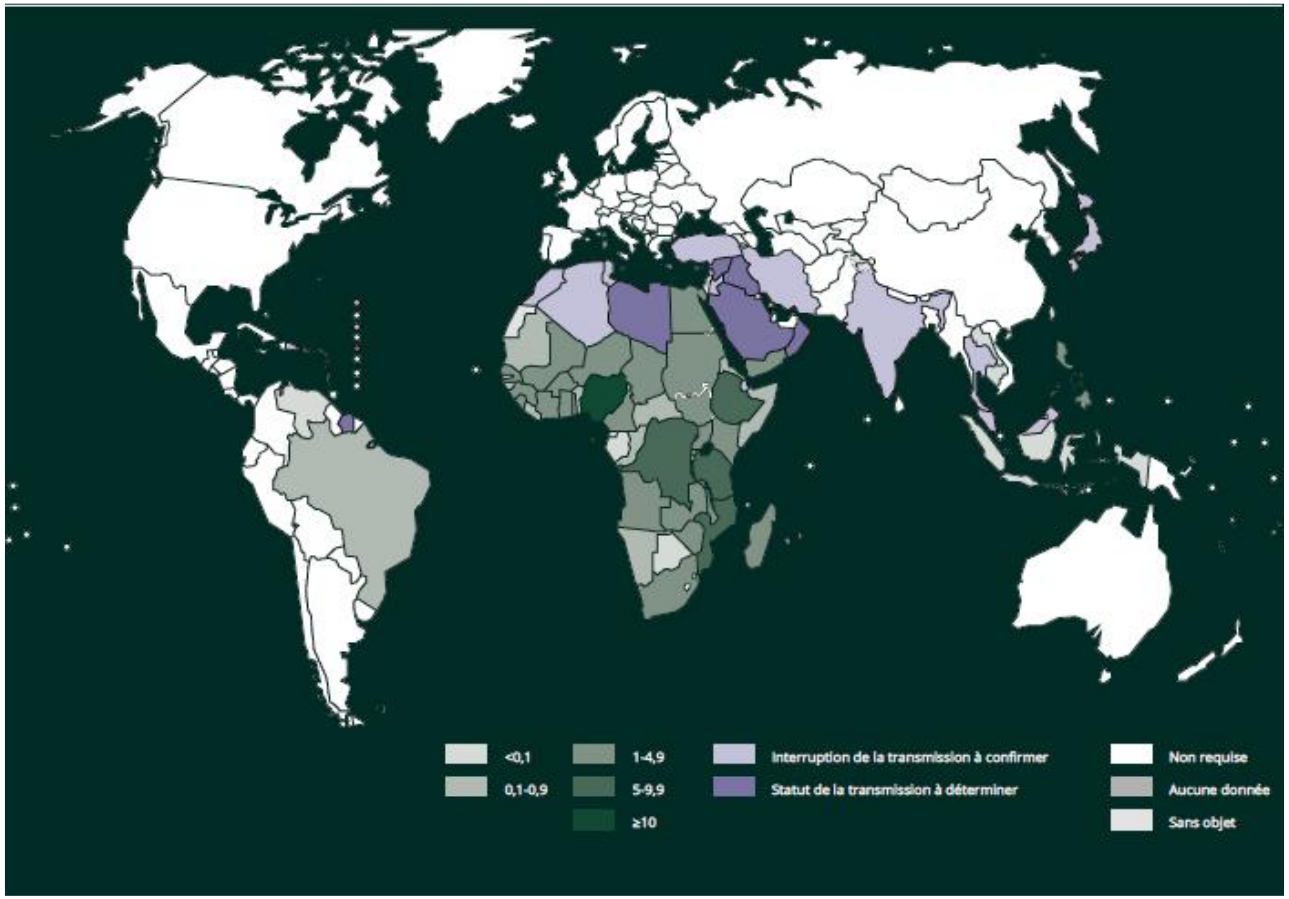
Global situation of schistosomiasis

- 78 Countries and territories are endemic
- 50 countries in need of preventive chemotherapy (PC), **41 of which are in Africa.**
- **264 million people requiring PC** in 2022 (**91%** in Africa)
- Publications and reports on transmission of schistosomiases in Nepal, Myanmar and India



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Schistosomiasis 2030 target, sub-target and milestones

WHO 2030 target, sub-targets and milestones

Indicator	2020 (provisional estimate)	2023	2025	2030
Number of countries validated for elimination as a public health problem (currently defined as <1% proportion of heavy intensity schistosomiasis infections)	0	49/78 (63%)	69/78 (88%)	78/78 (100%)
Number of countries where absence of infection in humans has been achieved	1/78 (1%)	10/78 (13%)	19/78 (24%)	25/78 (32%)

Justification:

. WHA65.21 calling for the elimination of schistosomiasis

. WHO Schistosomiasis: progress report 2001 - 2011, strategic plan 2012 – 2020 set the objective *to eliminate schistosomiasis as a public-health problem by 2025*.

. Impact of preventive chemotherapy in reducing the morbidity due to schistosomiasis

. Modelling of prevalence thresholds for preventive chemotherapy

At risk groups for schistosomiasis

- School-age children (Primary and secondary schools / in community)
- Preschool-age children
- Adults considered to be at risk, from special groups (pregnant and lactating women; groups with occupations involving contact with infested water, such as fishermen, farmers, irrigation workers, or women in their domestic tasks)
- Entire communities in high endemic areas

Strategic interventions for control and elimination of schistosomiasis

Preventive chemotherapy	▪ Regular treatment through mass drug administration with praziquantel of at-risk groups (school-aged children, pre-school aged children, communities in highly endemic areas, adults in occupations involving contact with infested water)
WASH	▪ Access to safe water ▪ Improved sanitation and management of excreta across communities (including animal waste) ▪ Individual hygiene education (e.g. use of toilets, personal hygiene)
Vector control	▪ Snail control with molluscicides, physical removal, and environmental modification
Veterinary public health	▪ Keeping animals away from transmission sites (for zoonotic transmission) especially in areas endemic for *S. japonicum* ▪ Treatment of animals with praziquantel
Case management	▪ Treatment with praziquantel on case by case basis and Individualized disease management (e.g., surgery and self-care) where appropriate
Other	▪ Behavioral change, self-care, and environmental management interventions

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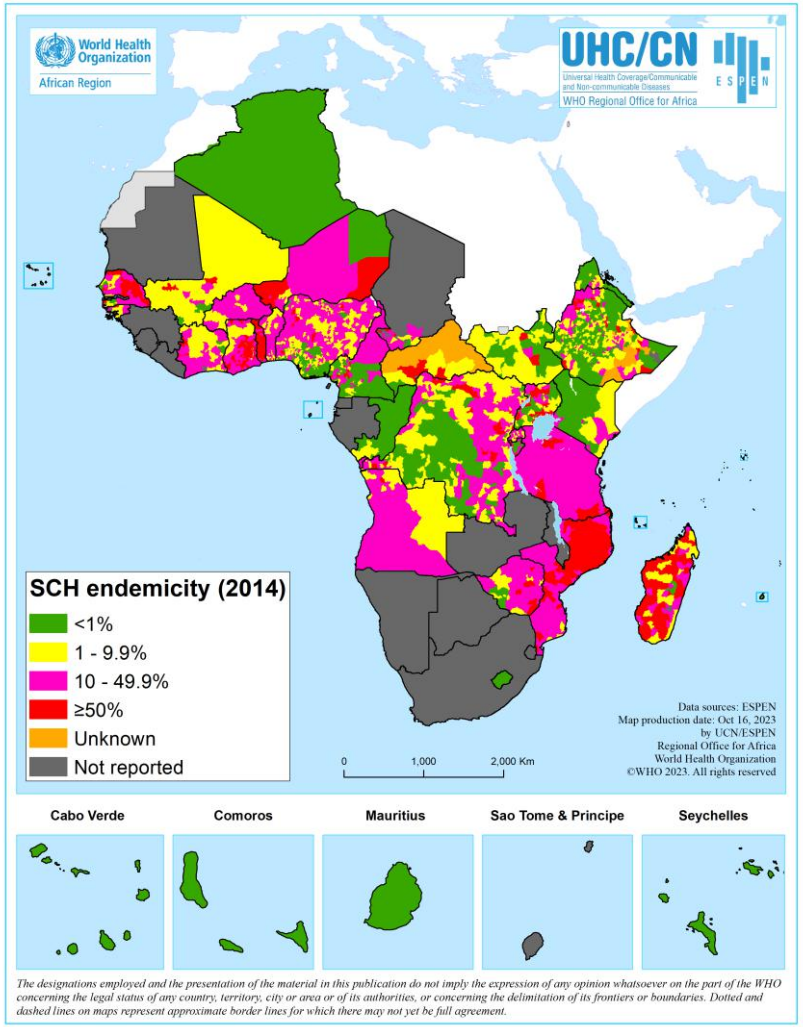
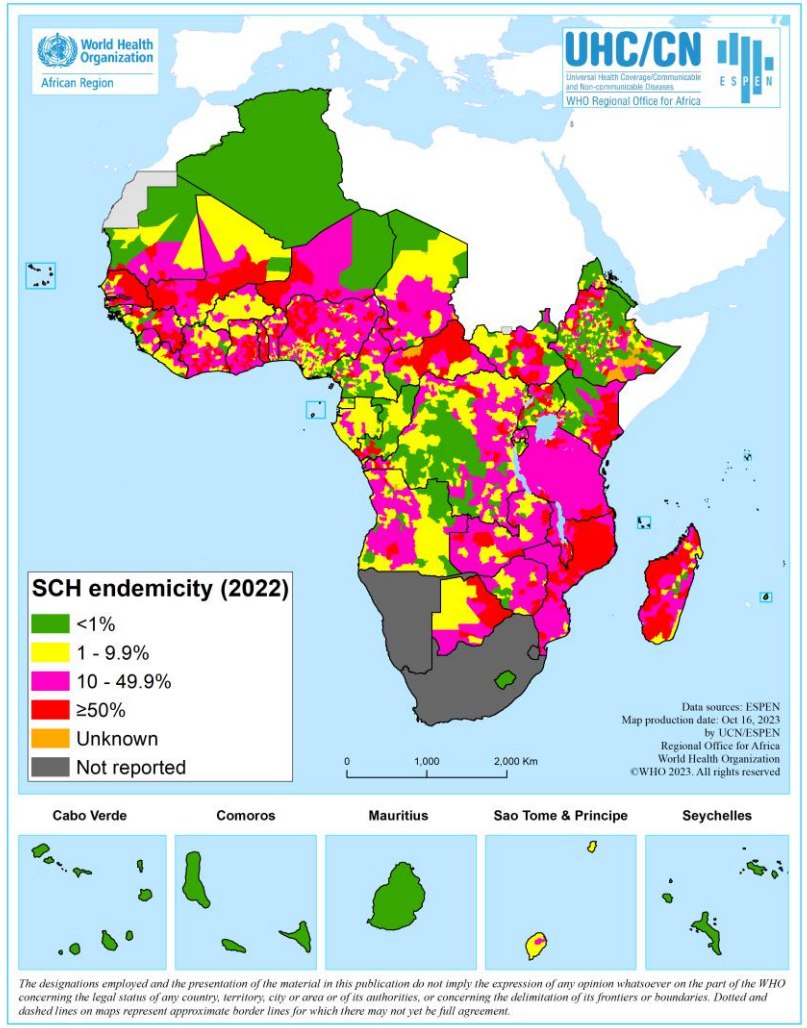
Key achievements - progress

- 43 countries considered endemic and 41 countries (*42 NTD programmes) requiring PC
- Only 2 countries, Eq. Guinea and south Africa, have not yet started PC.
- Cape Verde, Comoros, Lesotho, Mauritius and Seychelles considered non-endemic, and transmission not confirmed in Algeria
- 60.6% (51% - 75.5%) coverage achieved on school-age children (SAC) between 2014 and 2022.
- Low coverage in adults (15.4% in 2022) due to limited donation of PZQ
- 558.5M treatments delivered to school-aged children since 2014.
- Total treatments delivered to 85.2M people (SAC & adults) in 2022.
- Sub-district stratification to better target treatment is on-going.

Schistosomiasis – Endemicity





PC needed in 41 Countries

- 43 countries in the African region considered endemic for SCH,
- (Cape Verde, Comoros, Lesotho and Seychelles are non-endemic)
- 41 require PCT (Mauritius and Algeria require evaluation for elimination as PHP)
- By 2023, only 2 out of 41 countries had not yet started MDA for SCH (Equitorial Guinea and South Africa)

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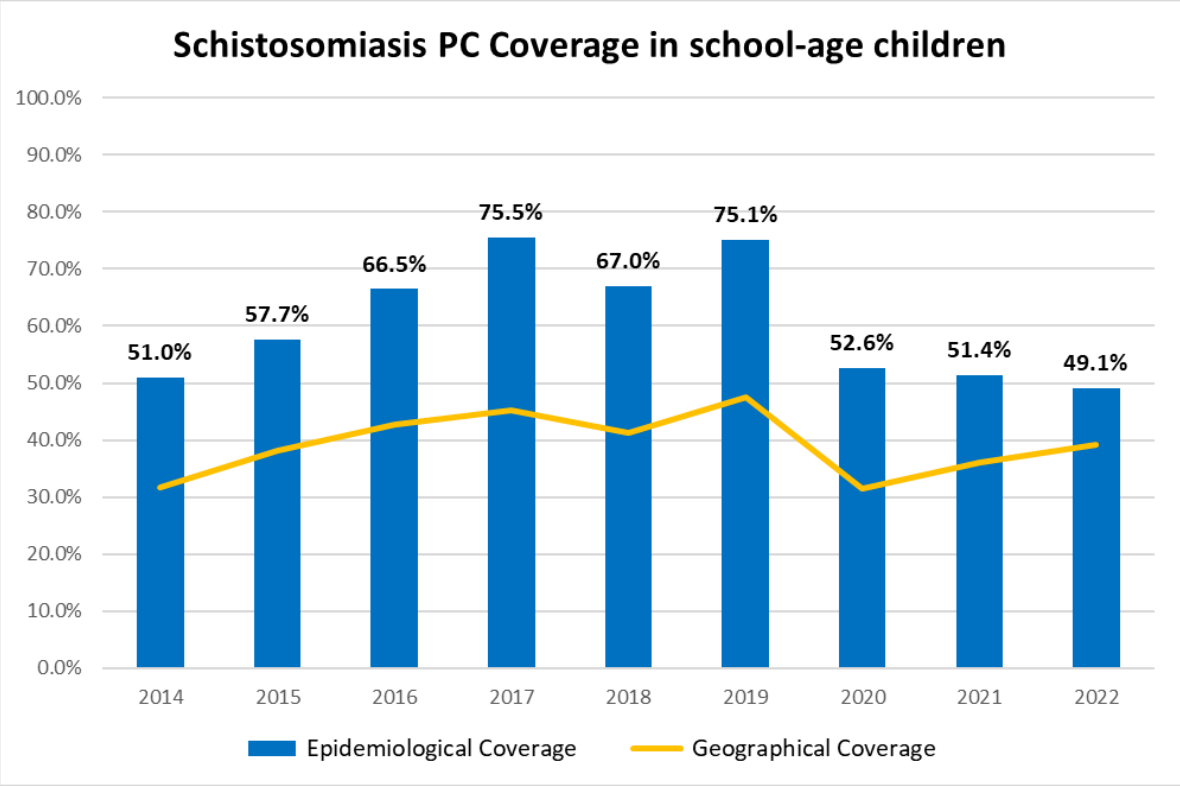
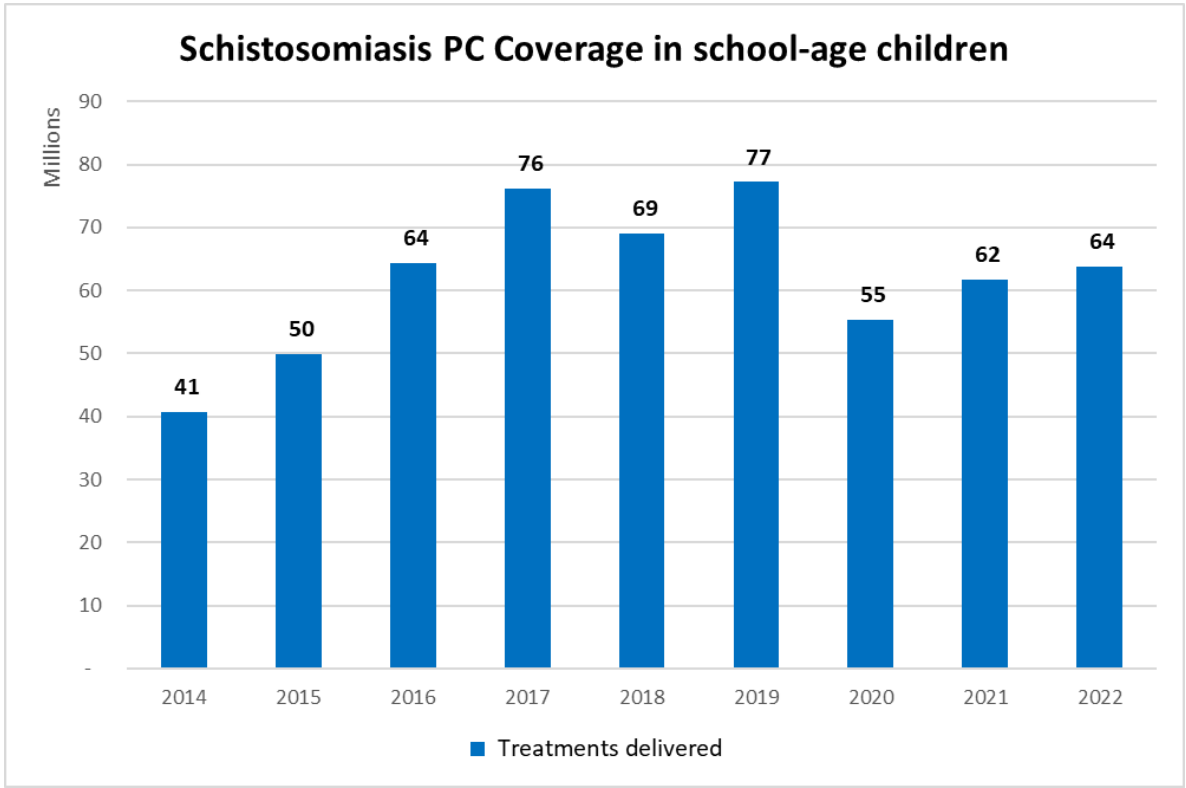
Schistosomiasis – PC delivered



2022 PC

- 79.4 million people treated (64 million SAC)
- 50.6% coverage for SAC in the African Region
- 93.6% of all treatment delivered globally was in the African Region



SCH PC Implementation Status 2023

MDA not started	MDA started but not at scale or irregular	MDA scaled to all IUs	Claimed to have interrupted transmission	MDA stopped in at least one focus
Equatorial Guinea South Africa	Angola, Congo, Nigeria, Somalia, Central African Republic, Chad, Gabon, Guinea Bissau, Sao Tome and Principle, South Sudan, Zambia, Namibia, Zimbabwe	Benin Burkina Faso Burundi Cameroon Côte d'Ivoire Democratic Republic of Congo Eritrea Ethiopia Gambia Ghana Guinea Kenya Liberia Madagascar Malawi Mali Mauritania Mozambique Niger Rwanda Senegal Sierra Leone Sudan Eswatini Togo United Republic of Tanzania Uganda	Mauritius	 Algeria *Need re-assessment of the situation*
2 (5%)	13 (30%)	27 (61%)	1 (2%)	1 (2%)

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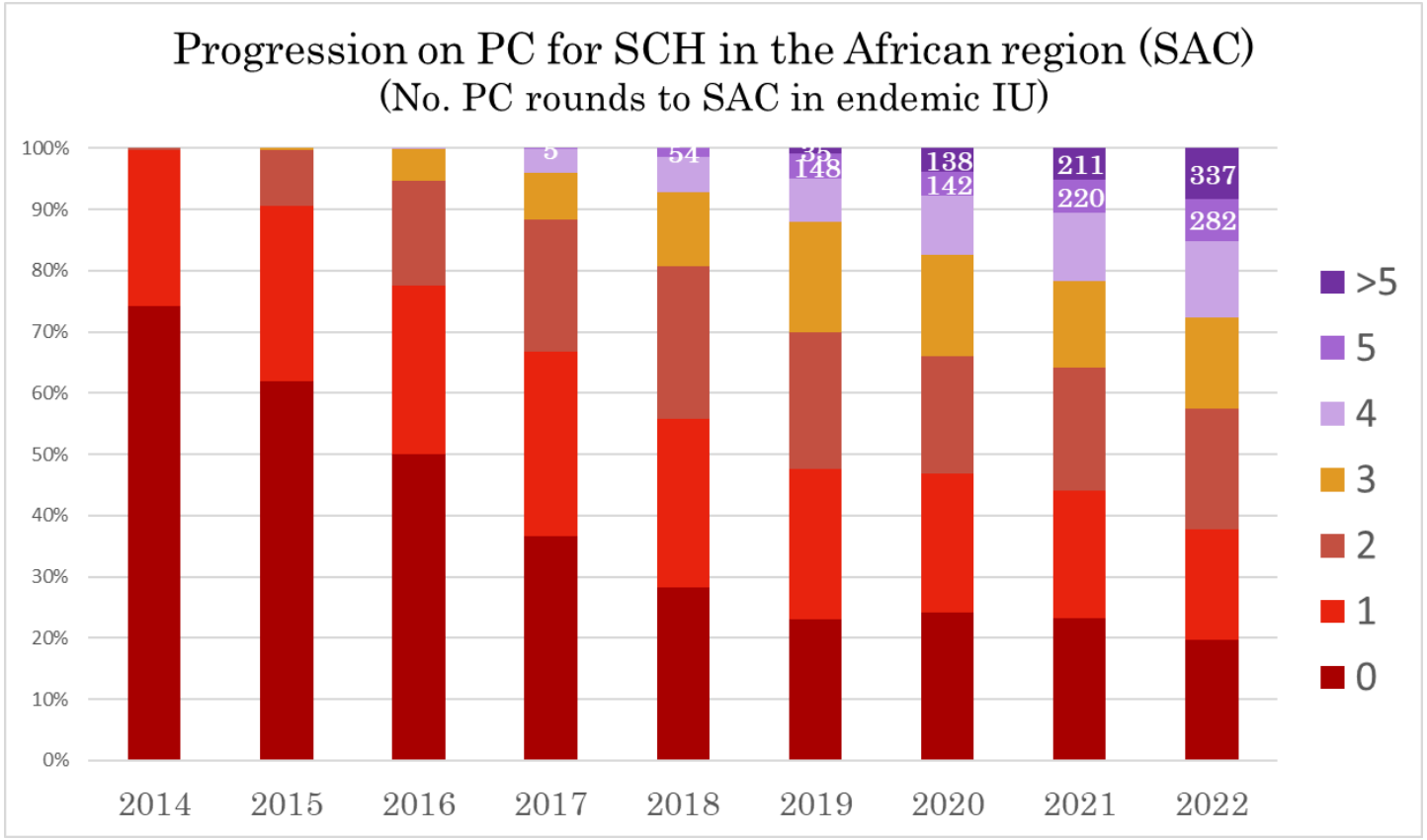
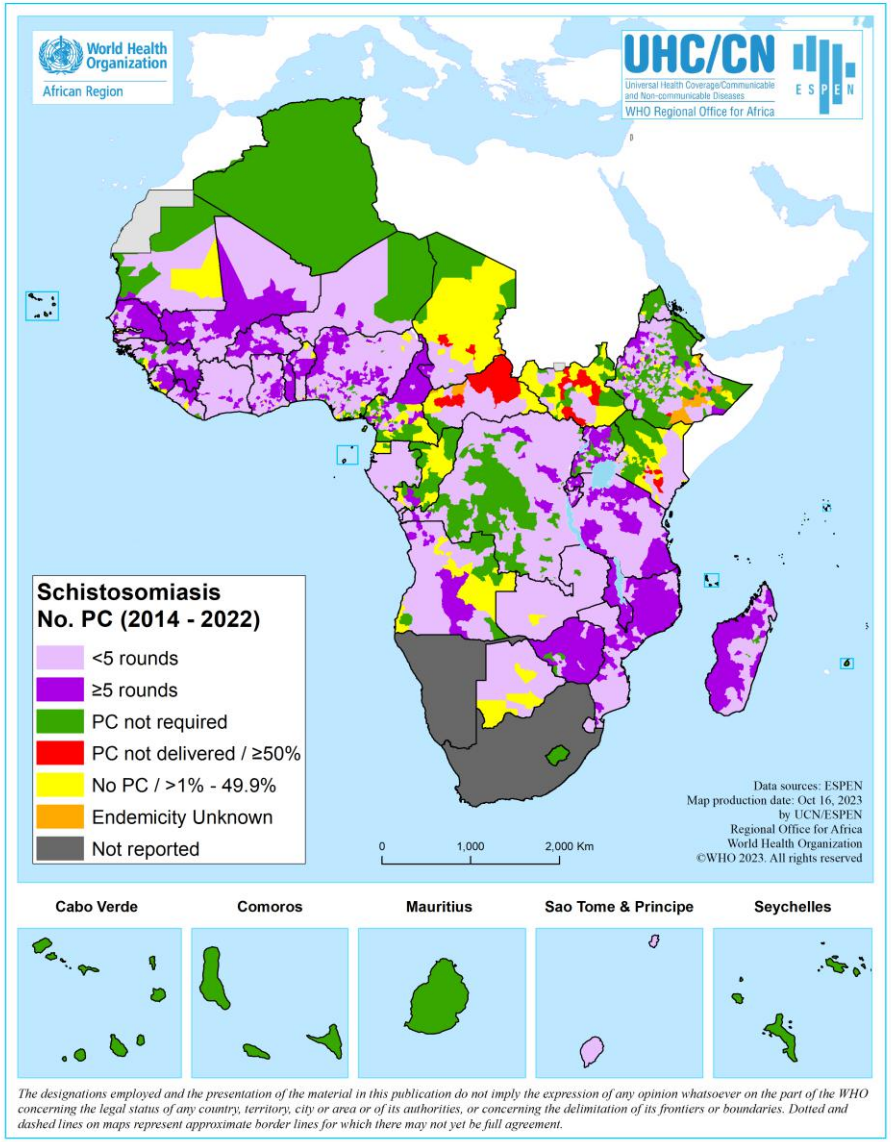
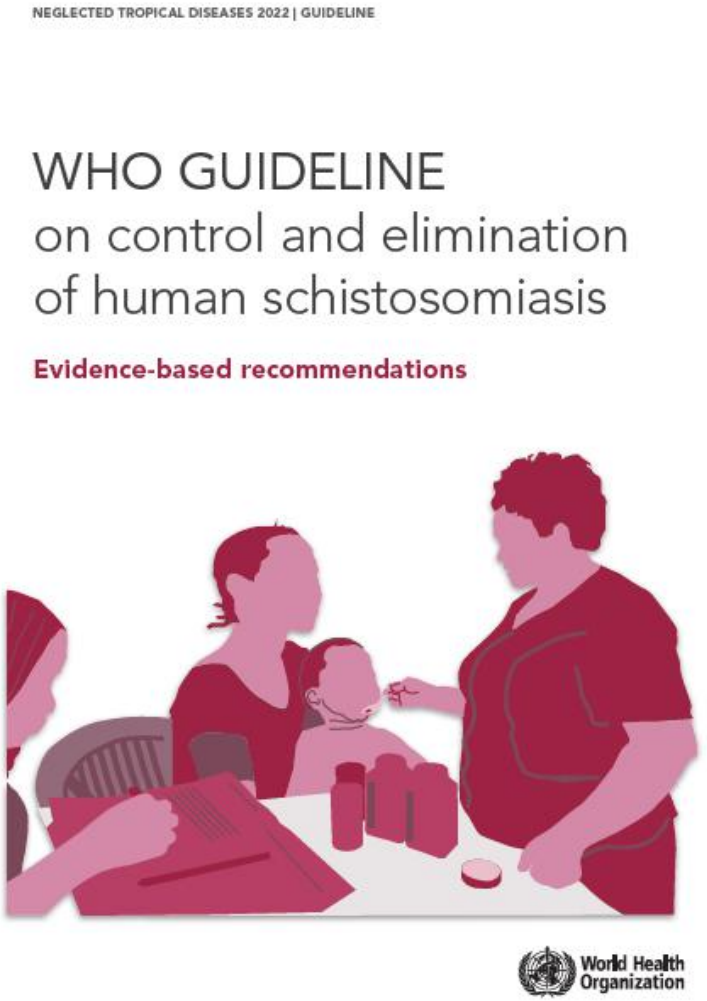
Schistosomiasis – PC progress in term of rounds of MDA





WHO guideline on control and elimination of human schistosomiasis



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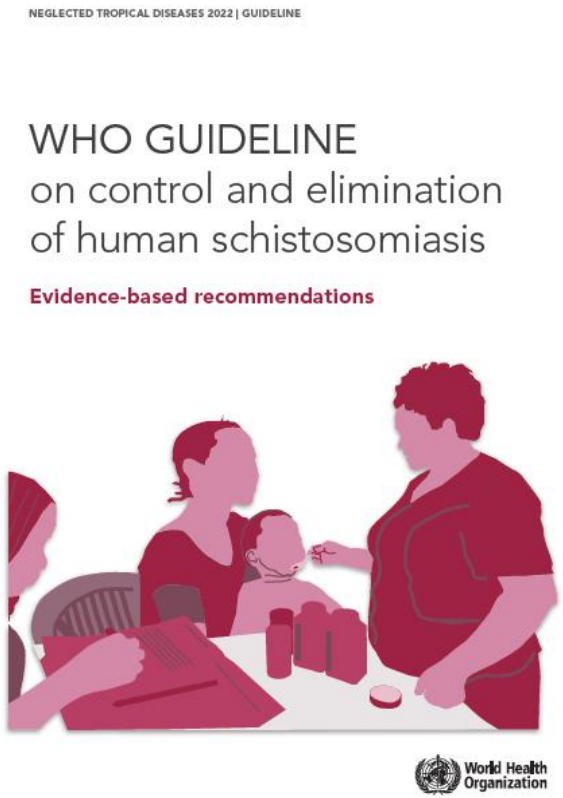
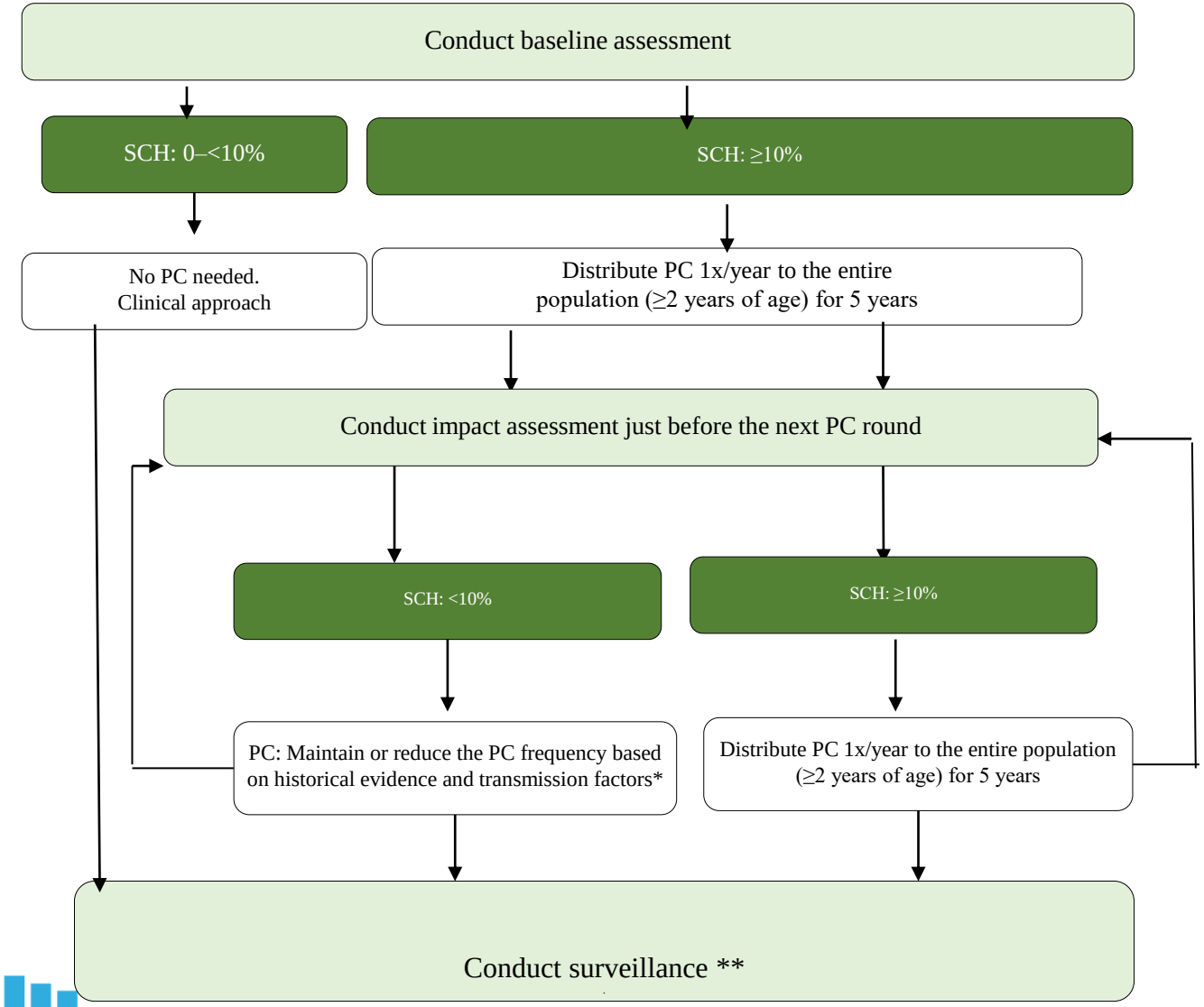
Evidence-based recommendations on:



- Simplified MDA - 10% threshold for implementing MDA
- Expansion of PC to all at risk groups from 2 years of age including pregnant and lactating women
- Promotion of health facility-based treatment for all
- Implementation of integrated strategy combining PC, snail control, environment management, WASH, one health
- Special PC frequency for high prevalence and in hot spots areas
- Recommendations on diagnosis strategy for verification of interruption of transmission in snails, animals and human

Standard approach



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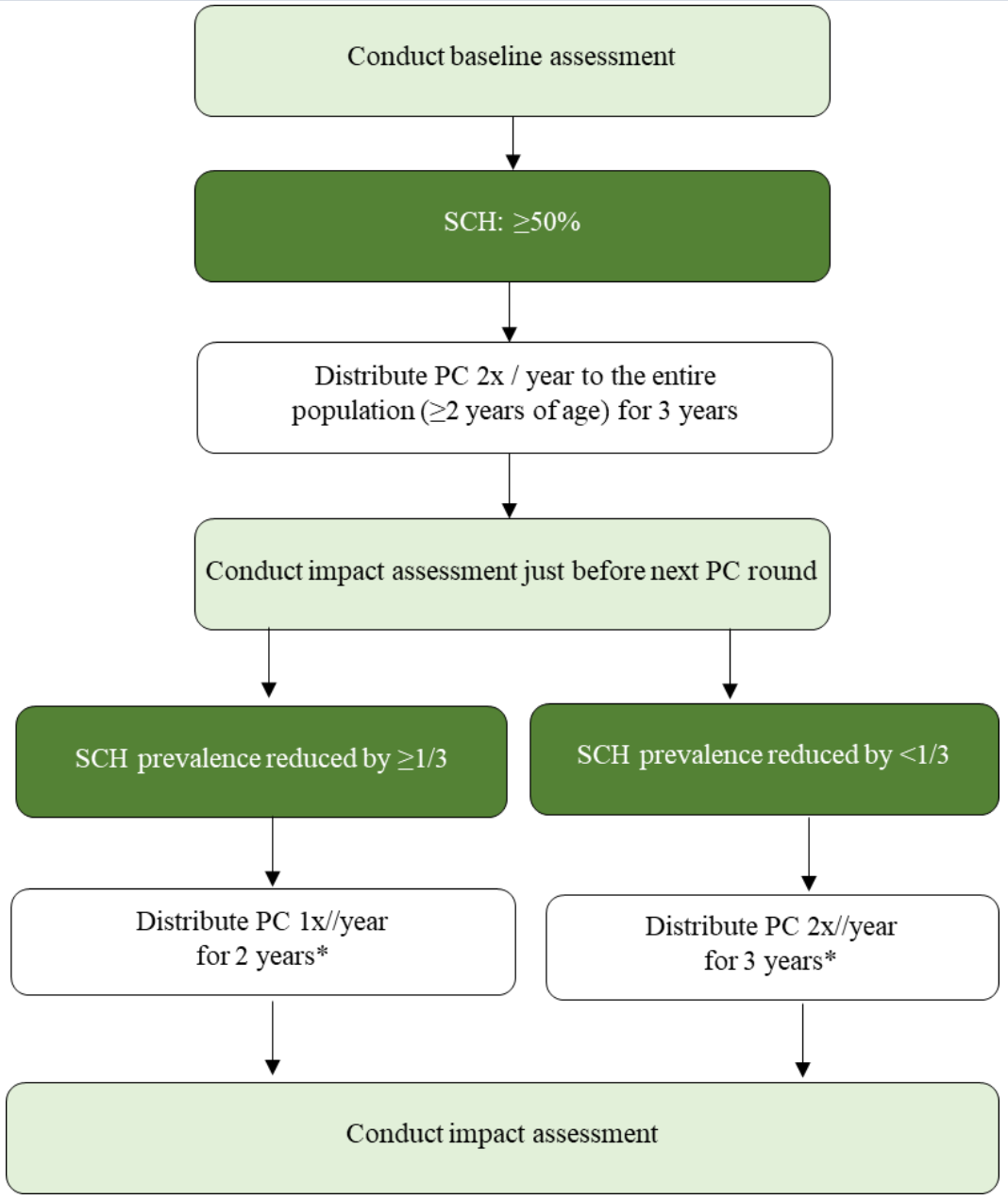
Special case 1. High prevalence areas (P≥50%)



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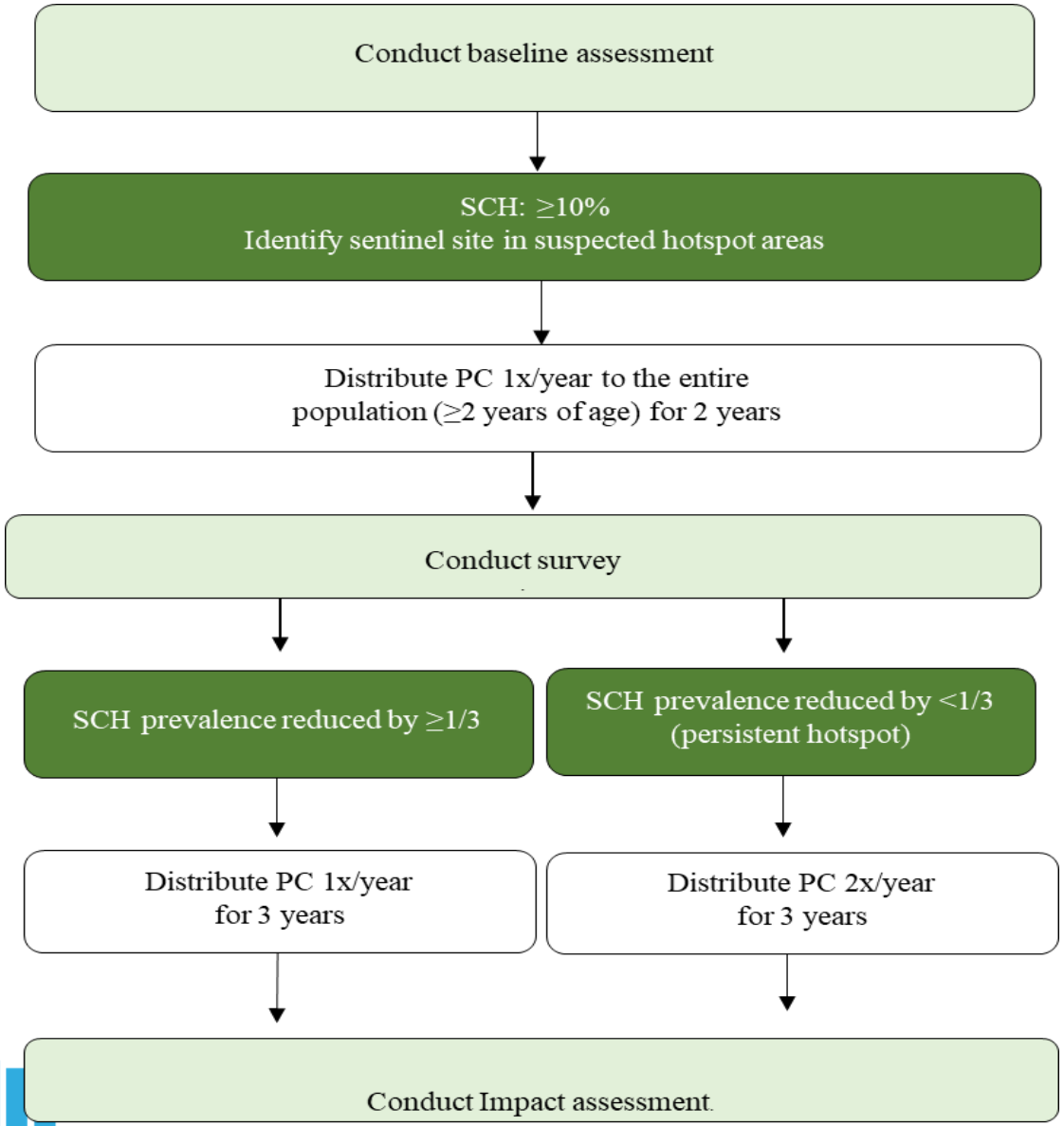
Special case 2: Hot spots



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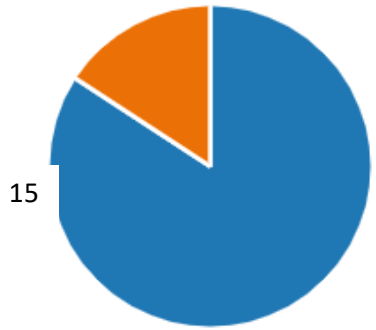
Use of the new WHO Schistosomiasis guideline

10. **Votre pays a-t-il distribué le PZQ en 2023, ou prévoit-il le faire?**

Plus de détails Aperçus

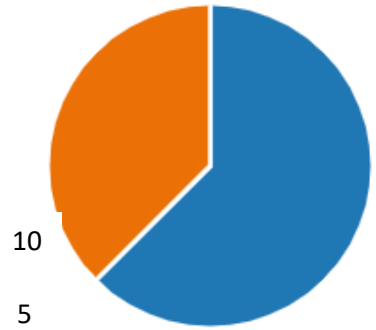
Oui	16
Non	3



11. **Si OUI, quelles directives de l'OMS ont été suivies, ou seront suivies?**

Plus de détails

Nouvelles directives de l'OMS (...	10
Anciennes directives de l'OMS (...	6
Ne sait pas	0



25 Countries responding

- Benin
- Botswana
- Burundi
- Cameroun
- Comores
- Congo
- Congo, RDC
- Eritrea
- Eswatini
- Ethiopia
- Gambia
- Ghana
- Guinée Bissau
- Guinée Equatoriale
- Malawi
- Mauritanie
- Niger
- Nigeria
- Rwanda
- Sao Tome and Principe
- Senegal
- Sierra Leone
- South Africa
- South Sudan
- Zimbabwe

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PRIORITY AREAS FOR COMING YEARS

- Scaling up impact assessment surveys in areas that have gone through more than 5 effective MDA rounds.
- Complete validation of sub-district SCH mapping for a better optimization of donated medicines.
- Need for better guidelines and protocols for post-MDA surveillance and strong surveillance systems to detect recrudescence and reintroduction.
- Monitoring concomitance with taeniasis/cysticercosis, and animal reservoirs.
- Clinical screening and morbidity management in adults
- Scaling up screening for FGS and interventions among affected WRA
- Delivering treatment to all target population according to updated WHO guidelines: all older than 2-yrs old.
- Integrated approach to control
  - ✓ Preventive chemotherapy
  - ✓ WASH
  - ✓ Snail control and environmental management

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Thank you

For more information, please contact:

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Soil- Transmitted Helminthiasis control programme: Overview and progress in the WHO African region

Dr Pauline Mwinzi

Technical Officer SCH/STH

World Health Organization African Region

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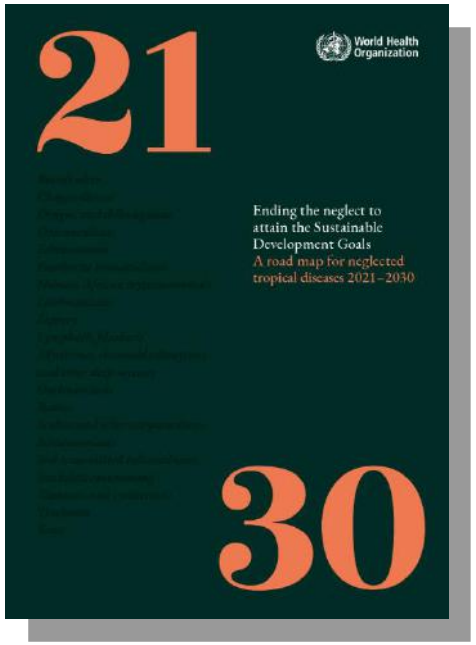
Background

- Soil-transmitted helminths include different species:
  - *Ascaris lumbricoides*
  - *Trichuris trichiura*
  - Hookworms *(Necator americanus and Ancylostoma duodenale)*
- *A. lumbricoides*, *T. trichiura* and hookworms do not multiply in the human host
- *Strongyloides stercoralis*: different diagnostic method and treatment (serology, Ivermectin)



The NTD road map 2021-2030 includes STH among the diseases targeted for elimination as a public health problem (EPHP)

EPHP is achieved when morbidity is kept under control

WHO 2030 target, sub-targets and milestones

Indicator[1]	2020 (baseline)	2023	2025	2030
Number of countries validated for elimination as a public health problem (defined as <2% proportion of soil-transmitted helminth infections of moderate and heavy intensity due to *Ascaris lumbricoides*, *Trichuris trichiura*, *Necator americanus* and *Ancylostoma duodenale*)[2]	0	60/101 (60%)	70/101 (70%)	96/101 (96%)
Number of countries including ivermectin in preventive chemotherapy in all areas endemic for *S. stercoralis*	0	10/101 (10%)	15/101 (15%)	96/101 (96%)

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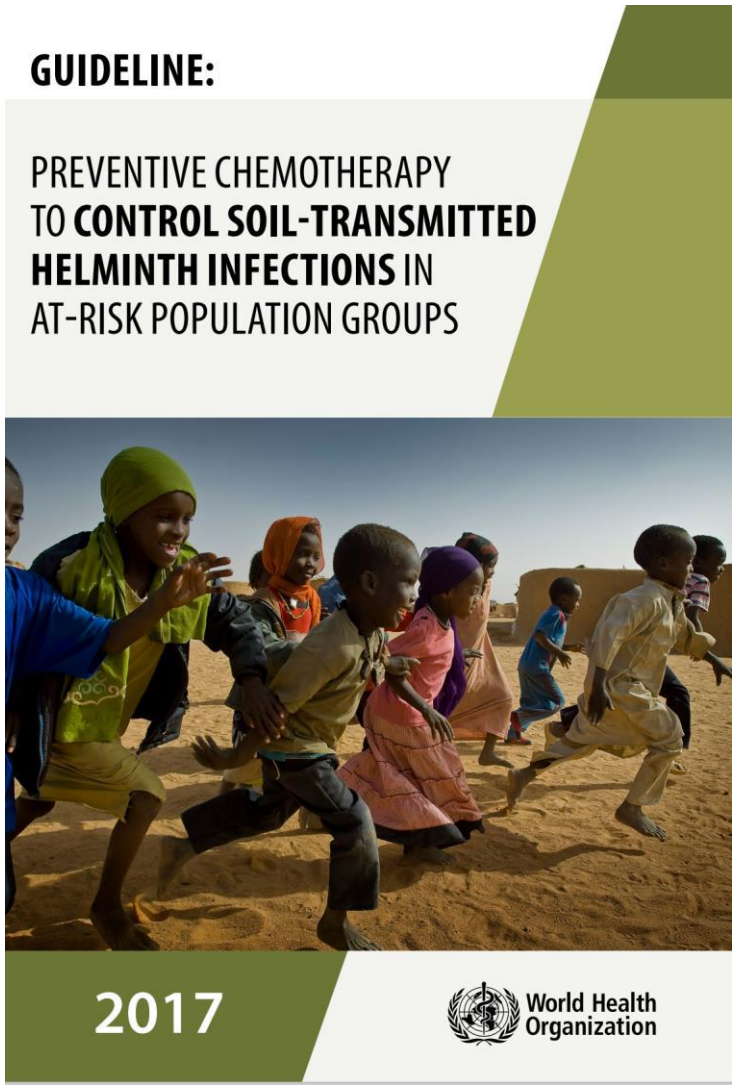
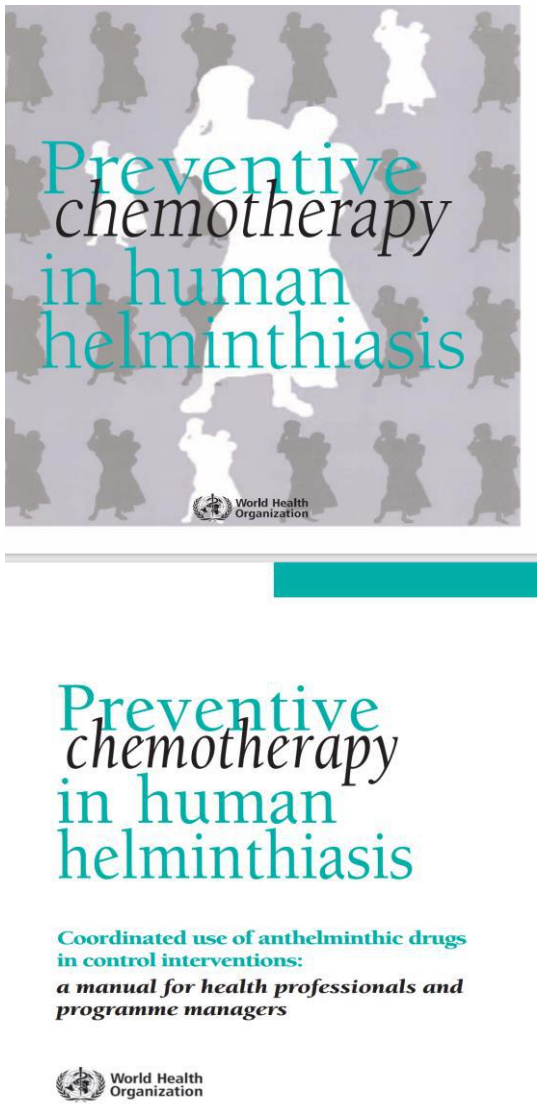
Strategies for elimination of STH as a public health problem

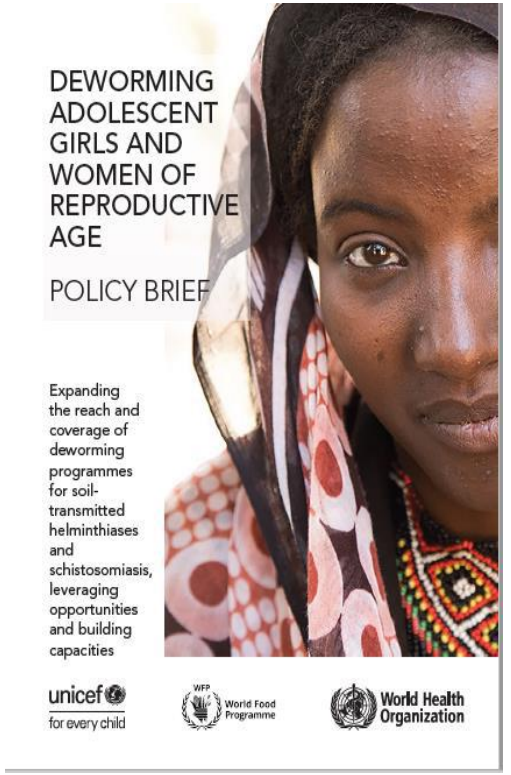
- **Preventive chemotherapy in areas with prevalence >=20%**, targeting 3 risk groups:
  - pre-school children (pre- SAC)
  - school-age children (SAC)
  - women of reproductive age (WRA)
- **Frequency:**
  - Once a year (where prevalence is <50%)
  - Twice a year (where prevalence is ≥50%)
- **Integrating** drug distribution with the existing structures (school system, vitamin A distribution activities, women union) and personnel (teachers, village health workers) - >>> reducing logistics cost
- **Health education messages**
- **Provision of safe water, sanitation and hygiene services** is fundamental, to break the cycle of infection

- *Regular treatment for several years reduces and keeps low the number of worms in each child, thus preventing the development of morbidity*

Current guidelines and operational guidance







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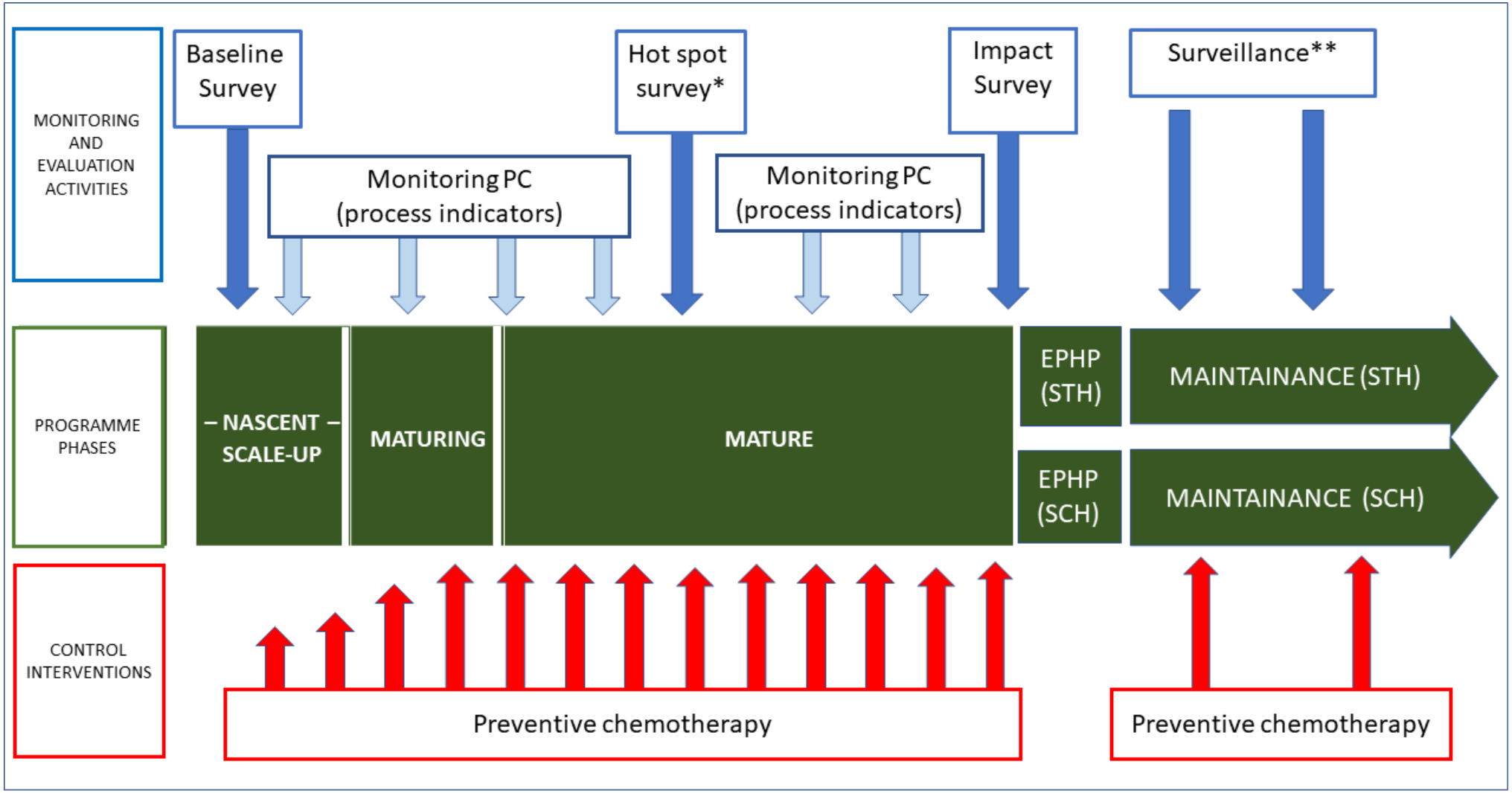
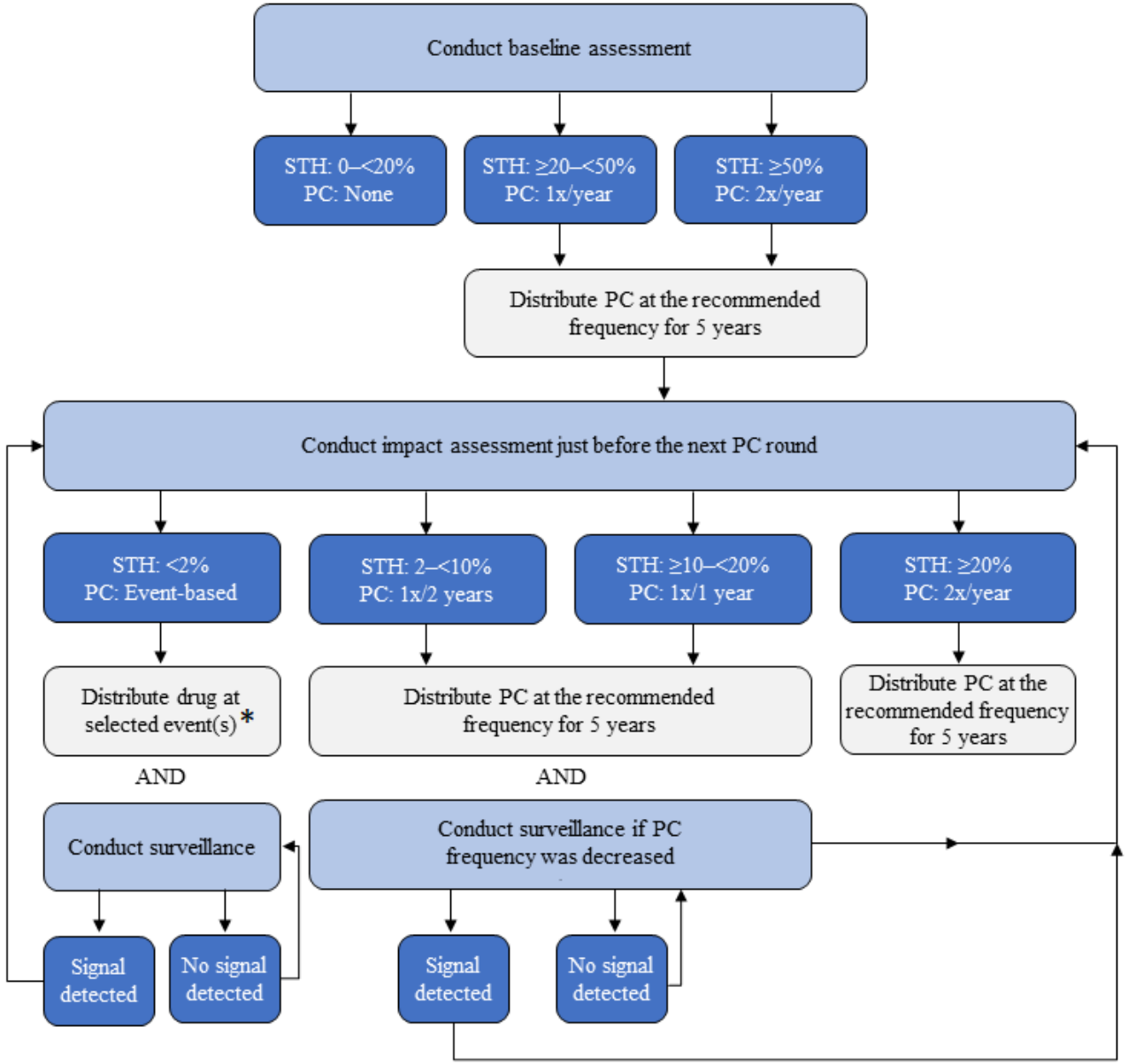
Monitoring and Evaluation framework



Decision tree for frequency of PC distribution for STH

*Note: The elimination of STH as a public health problem is defined as a prevalence of moderate-to-heavy intensity infection of <2% among children. While this is an important indicator to monitor the progress of STH control, it is **not** considered for the purpose of making decisions on the frequency of PC distribution.*

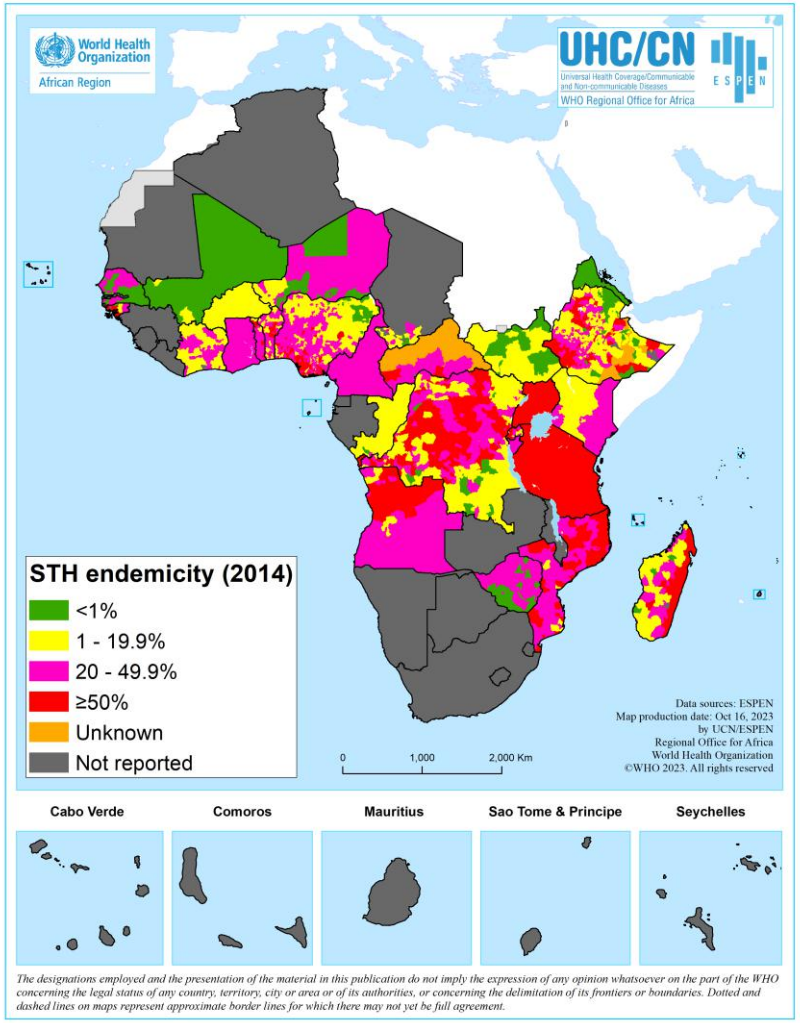


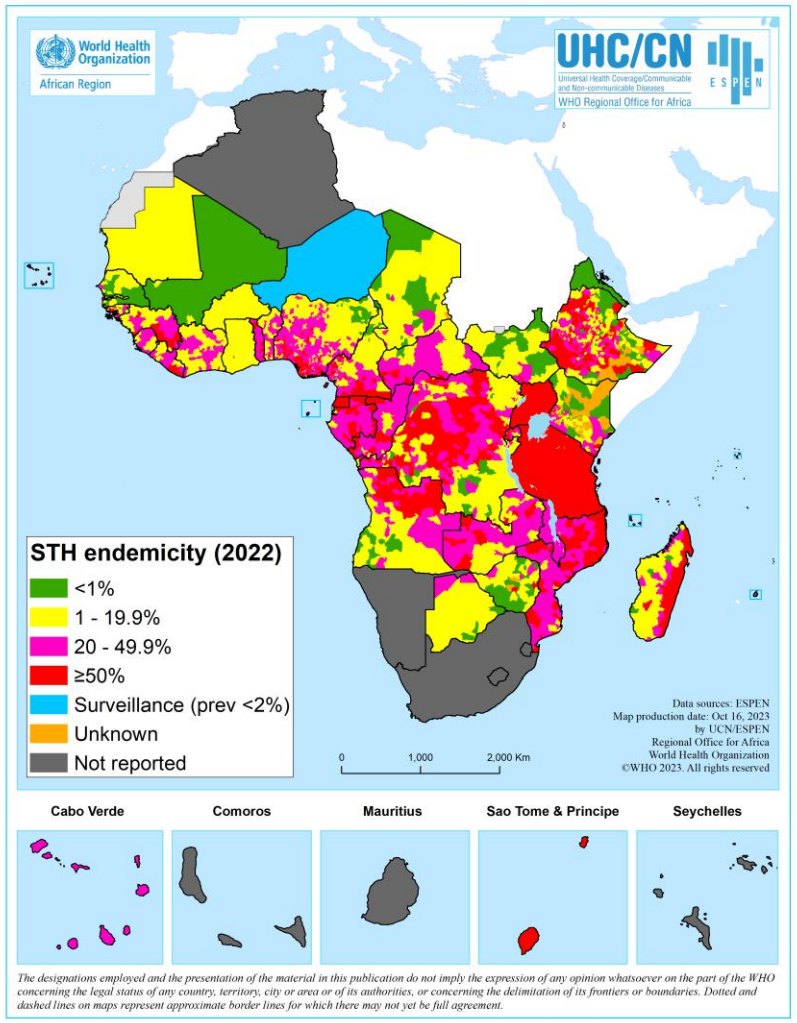
* PC targeting entire age groups may be suspended, but distribution may continue in appropriate settings (e.g., selected child-health visits, selected school years, or at antenatal care visits)

Key achievements - progress

- All 47 countries in the African region considered endemic for STH but only 42 are requiring PC (Algeria, Eritrea , Seychelles, Mauritius and Mauritania do not need PC)
- By 2022, 4 out of 42 countries requiring PC for STH are thought to have reduced transmission below PC threshold (prevalence 2%): Burkina Faso, Mali, Ghana, and Niger.
- 80.1% (62.1% - 95.5%) coverage achieved on school-age children (SAC) between 2014 and 2022.
- Low coverage on preschool-age children (25.8% in 2022), although underestimated because delivered out of WHO programme (UNICEF, etc).
- 1.13 billion treatments delivered to school-aged children since 2014.
- Benefitted from community level PC in areas co-endemic for LF, resulting in highest coverage on SAC population but also covered 20% of women of reproductive age in need of PC for STH.

Soil Transmitted Helminthiases – Endemicity





PC needed in 42 Countries

- All 47 countries in the African region considered endemic for STH.
- 42 countries are need of PC *(Algeria, Eritrea , Seychelles, Mauritius and Mauritania do not need PC)*

- By 2022, 4 out of 43 countries requiring PC for STH are thought to have reduced transmission below PC threshold: Burkina Faso, Ghana Mali and Niger.

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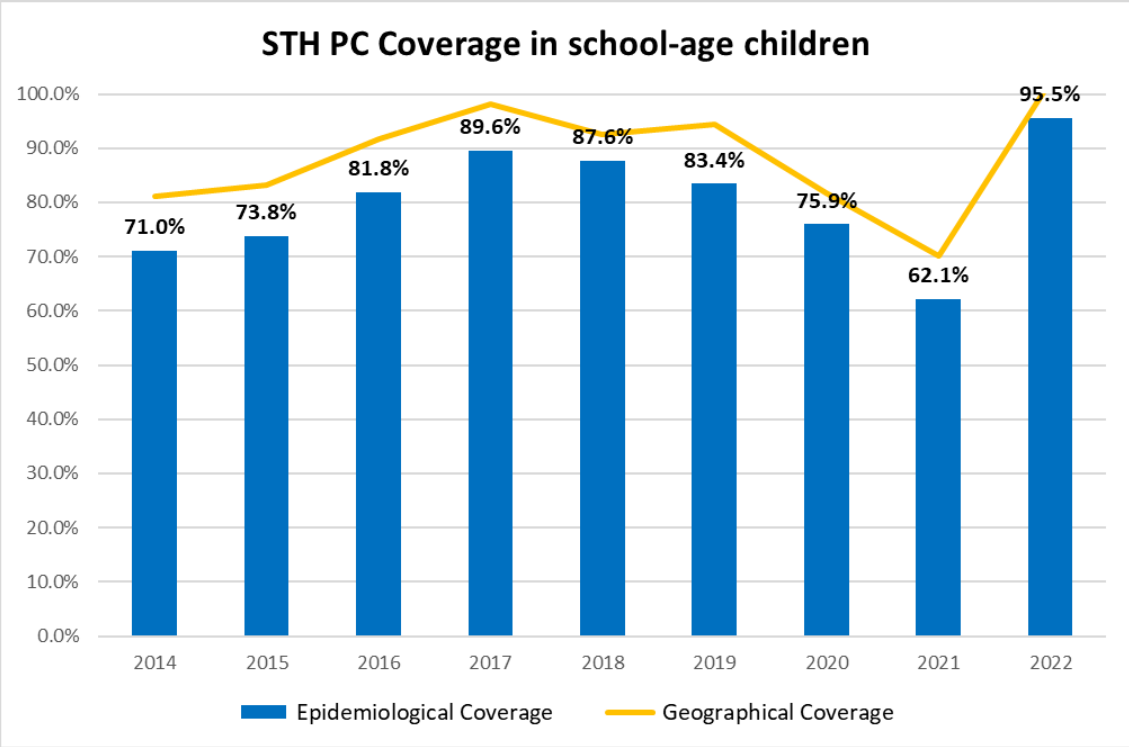
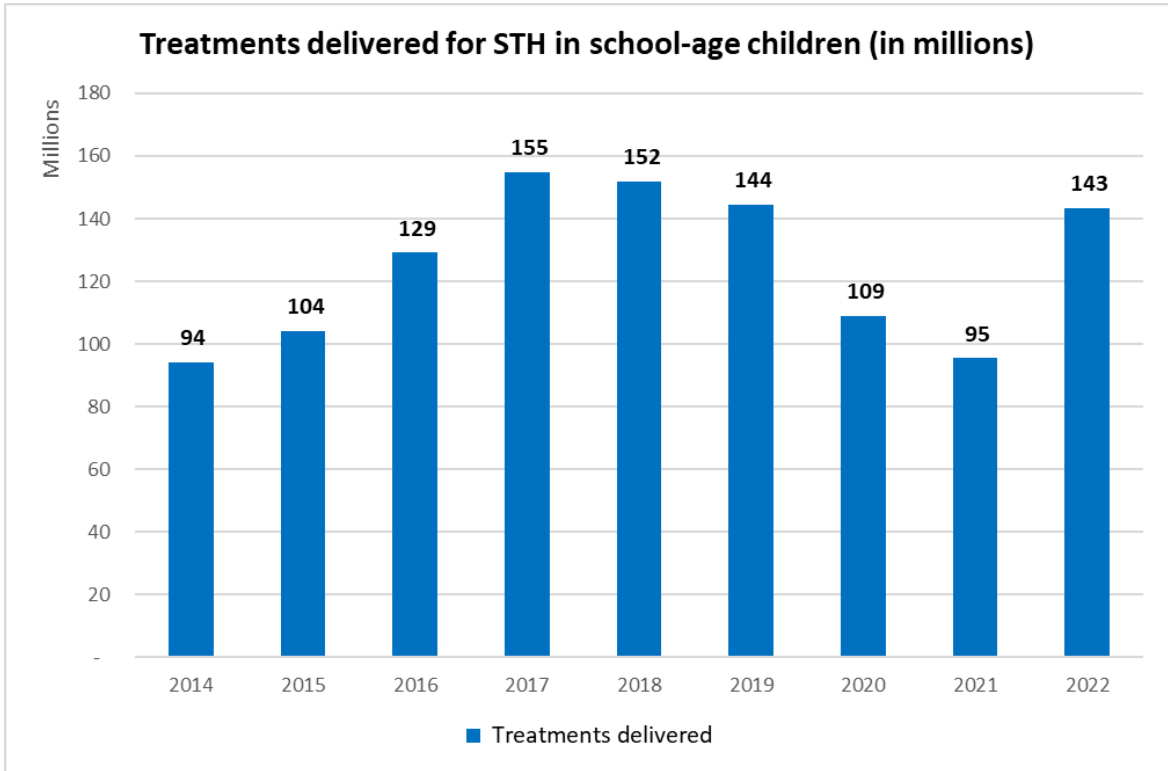
Soil Transmitted Helminthiases – PC delivered





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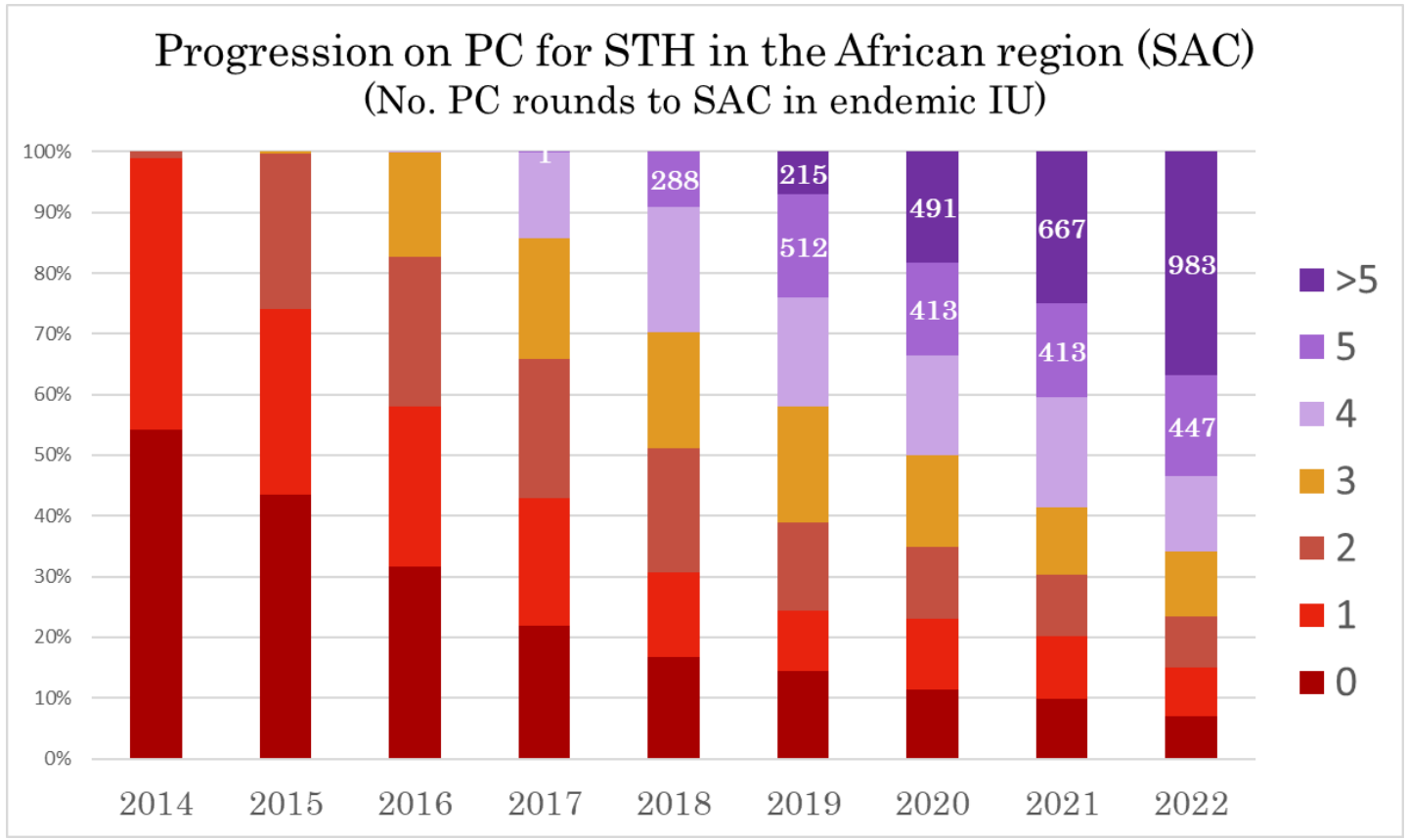
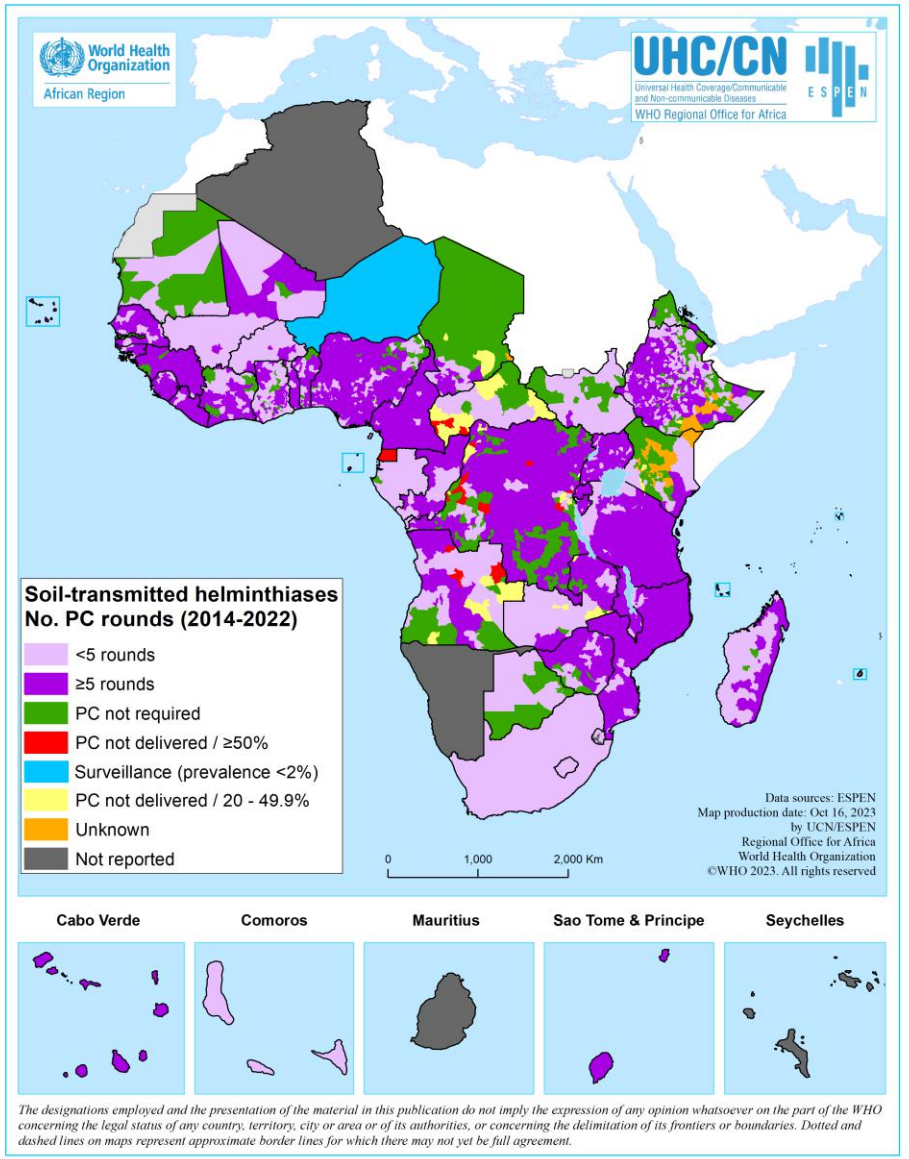
Soil Transmitted Helminthiases – PC progress





STH PC Implementation Status as of 2023

Countries without implementation of preventive chemotherapy (PC) or have halted PC

Lesotho
Namibia

2 (4.8%)

Countries with PC implementation in 2022 with <75% national coverage

Angola
Cameroon
Cabo Verde
Chad
Comoros
Congo
Gabon
Guinea Bissau
Madagascar
Malawi
Sao Tome and Principe
United Republic of Tanzania
Zimbabwe*

13 (30.9%)

Countries with PC implementation in 2022 with ≥75% national coverage

Benin
Burundi
Côte d'Ivoire
Democratic Republic of Congo
Ethiopia
Guinea
Kenya
Liberia
Mozambique
Nigeria
Rwanda
Senegal
Sierra Leone
South Sudan
Togo
Uganda

16 (38.1%)

Countries with prevalence <2% of intensity infections moderate to high and have probably achieved Elimination as PHP, pending validation

Burkina Faso
Mali
Niger
Ghana

4 (9.5%)

Countries which do not report on time

Botswana
Central African Republic
Eswatini
Equatorial Guinea
Gambia
South Africa
Zambia

7(16.7%)

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Priority areas for coming years

- Scaling up impact assessment surveys in areas that have gone through more than 5 effective MDA rounds.
- Need for better guidelines and protocols for post-MDA surveillance and strong surveillance systems to detect recrudescence.
- Foster multisectoral integrated approach required for control (Education, Health, WASH).
- Delivering treatment to all target population including pre-SAC and women of reproductive age (WRA).
- Where LF and STH are co-endemic, ensuring PC interventions continue when LF MDA is interrupted.

Thank you

For more information, please contact:

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Onchocerciasis and Lymphatic filariasis: Overview and progress in the WHO African region

Dr Didier Bakajika

Medical Officer LF/Onchocerciasis

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Lymphatic filariasis

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Lymphatic Filariasis- Background

Overview

- Disease caused by the infection with *W. bancrofti*, *B. malayi* and *B. timori*
- Infection transmitted by mosquito species from the genera *Culex, **Anopheles**, Mansonia and Aedes*
- Endemic in 72 countries worldwide
- Two pillars of the program (GPELF):

  Interruption of transmission (MDA)

  Alleviation of suffering (MMDP)

Core strategic Interventions

- Preventive chemotherapy (IVM/ALB, ALB2x, DA/IDA)
- Case management (MMDP)/ Essential package of care
- Integrated Vector control management
- WASH : Impact of sanitation improvements on vector breeding habitats

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2030 targets and sub targets for Lymphatic filariasis

Indicator	2020	2023	2025	2030
Number of countries validated for Elimination of LF as PHP	**17**	**23**	**34**	**58**
Number of countries implementing post MDA or post validation surveillance	26	37	40	72
Population requiring MDA (million)		330	180	0

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Lymphatic Filariasis – Summaries Progress in AFRO region

- 34 endemic countries in the region: 25 need MDA
- 2 countries have eliminated LF as PHP, 7 stopped MDA in all endemic IUs and 12 in at least one IU.
- 299.9M requiring PC against LF in 2022 from 345.6M in 2014.
- Between 2014 and 2022, over 1.55 billion (1,555,902,212) people covered with PC against LF.

- Population no longer needing PC increased from 37.4M in 2014 to 231.3M in 2022.
- 977 endemic IUs under post-MDA surveillance in 2022 from 160 in 2014.
- 96 IUs pending to complete their transmission assessments by 2022.
- From **21/34** countries reporting LF morbidity care: 17,562 lymphedema cases and 15,895 hydrocele cases reported in 2022

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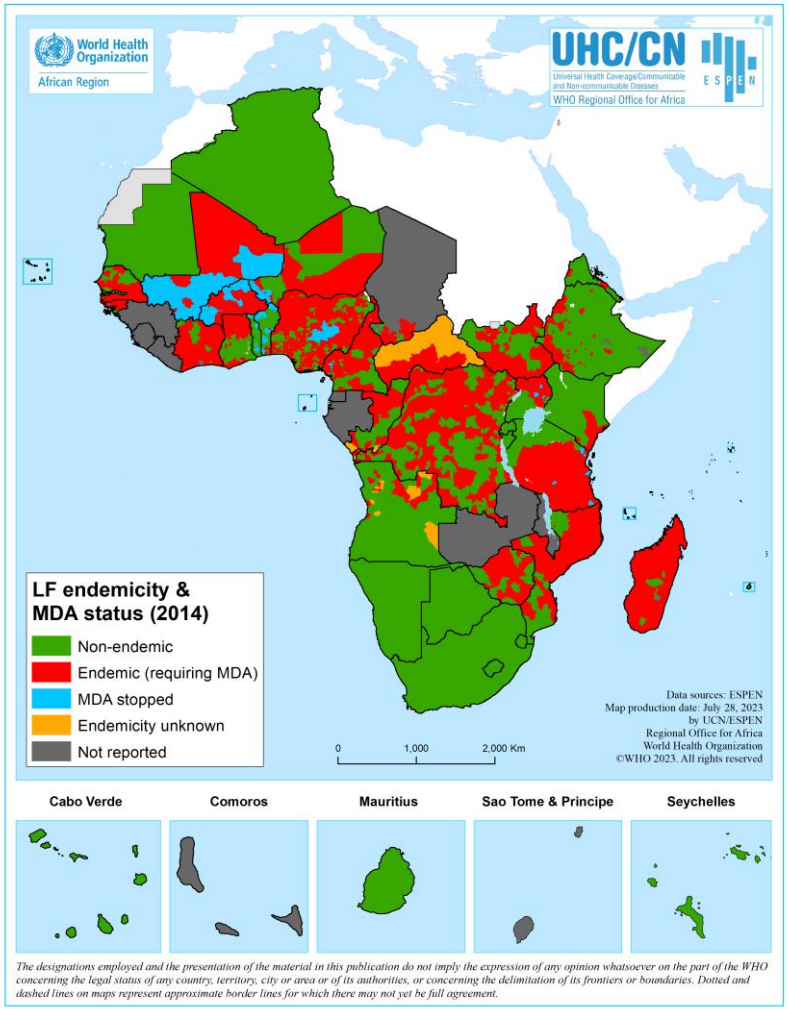
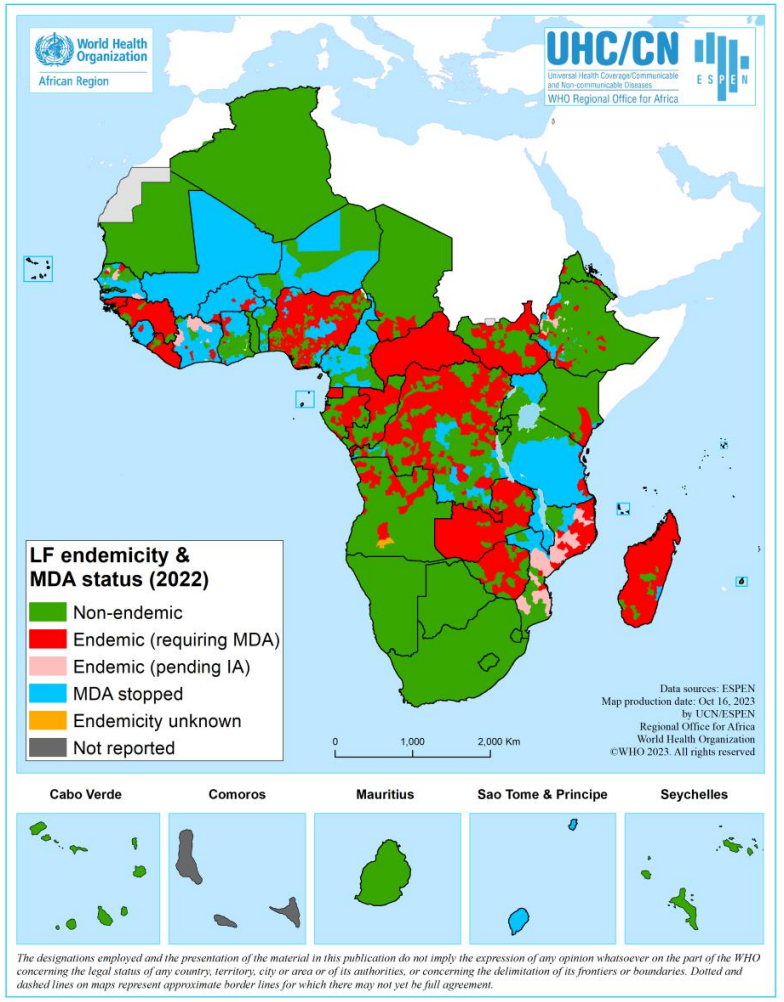
Lymphatic Filariasis – Endemicity





MDA needed in 25 Countries (out of 34 endemic)

- 21 countries implementing full geographic coverage
- 3 countries implementing MDA but not to scale
- 1 country not started MDA (Gabon)
- 7 countries have stopped MDA in all endemic IUs: Benin, Cameroon, Comoros, Eritrea, Mali, Sao Tome & Principe, and Uganda.

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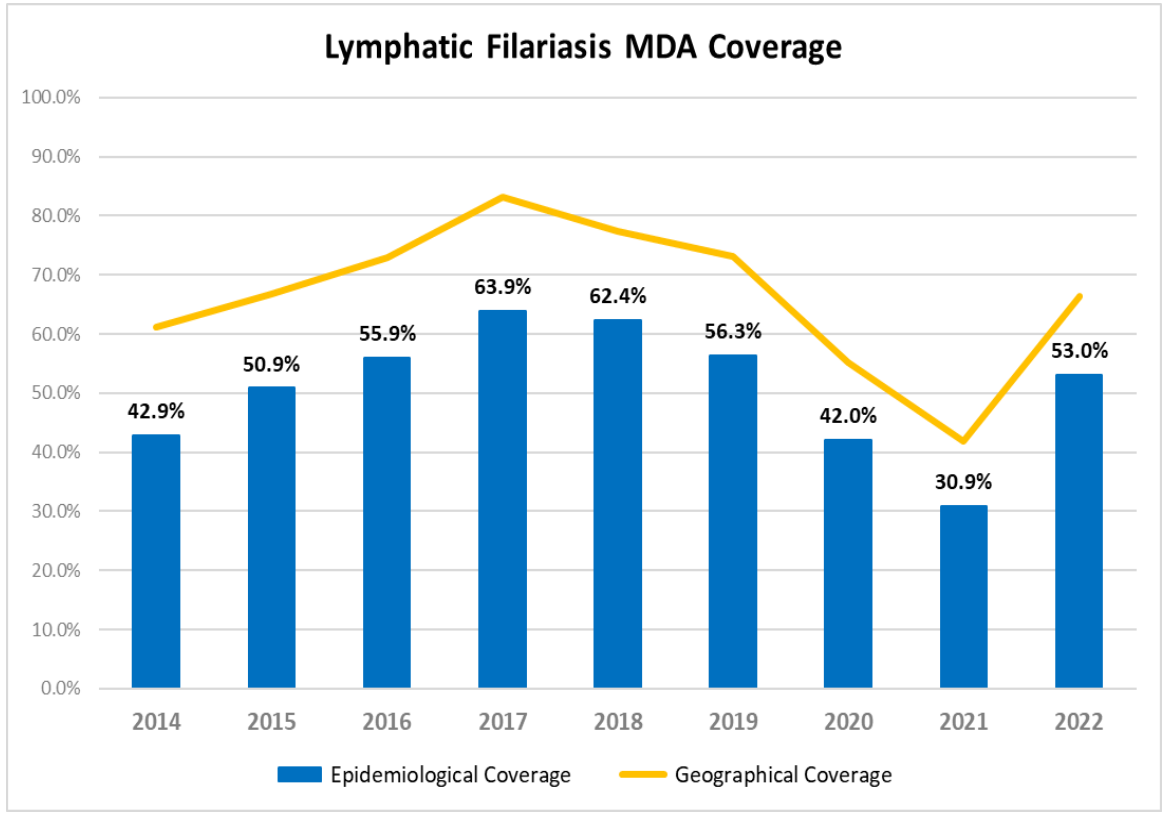
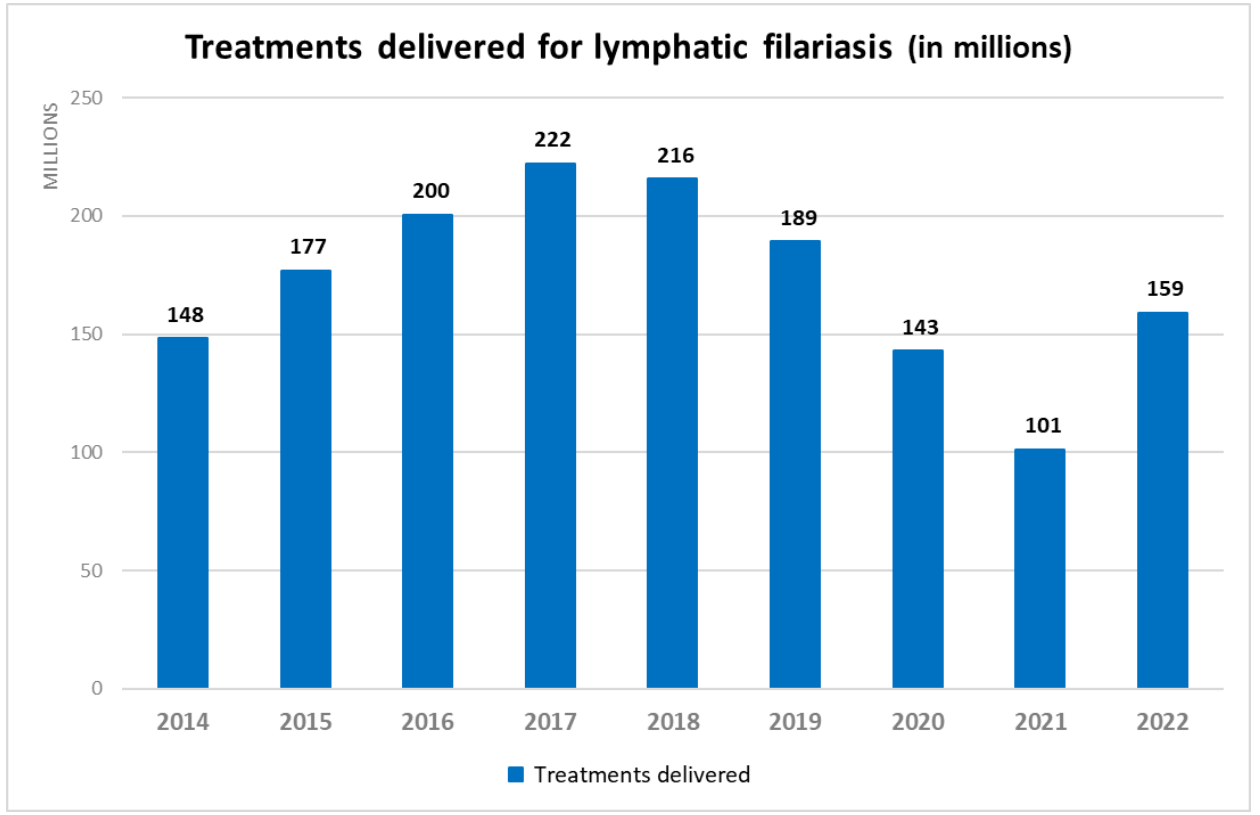
Lymphatic Filariasis – MDA delivered





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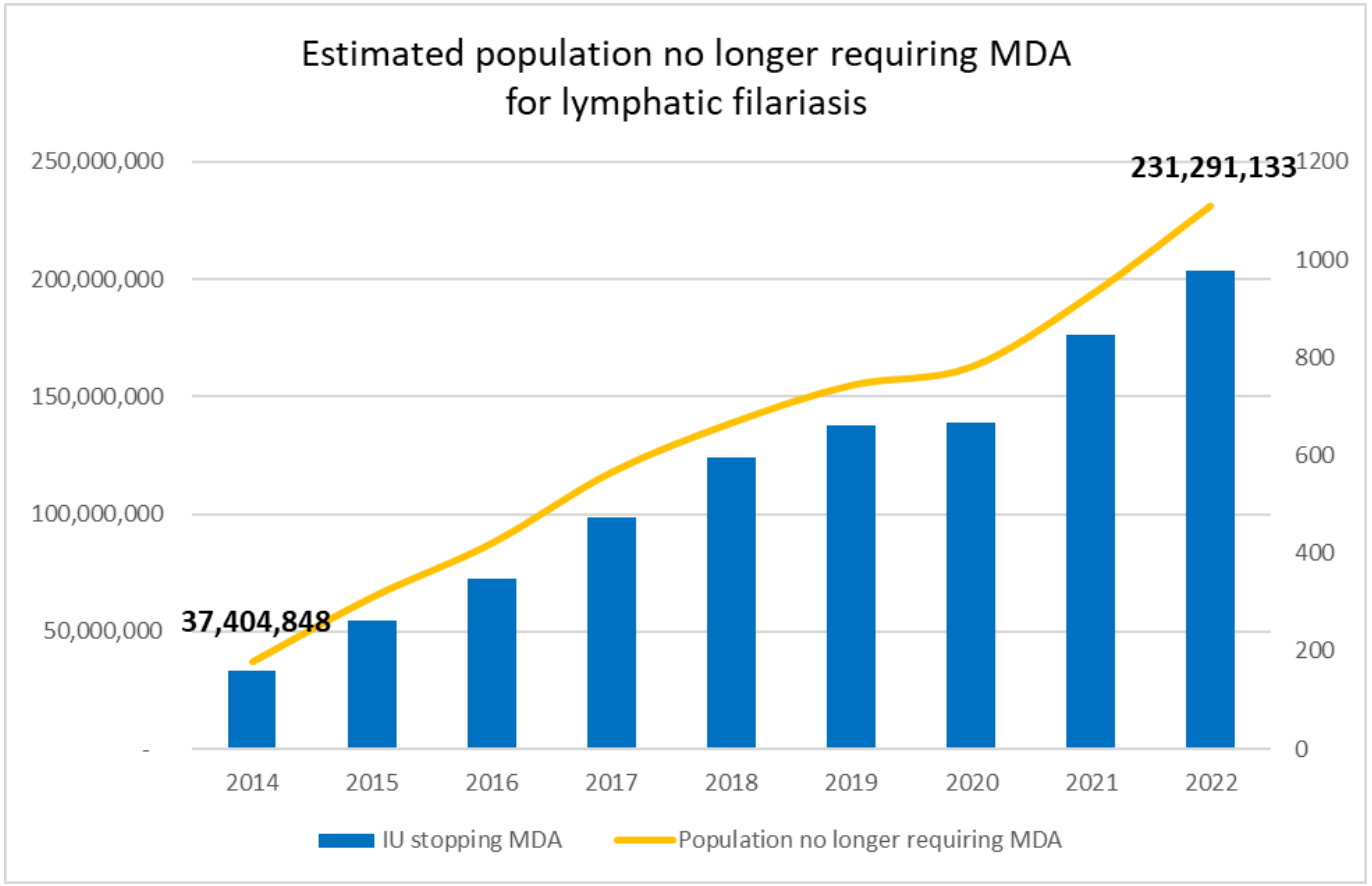
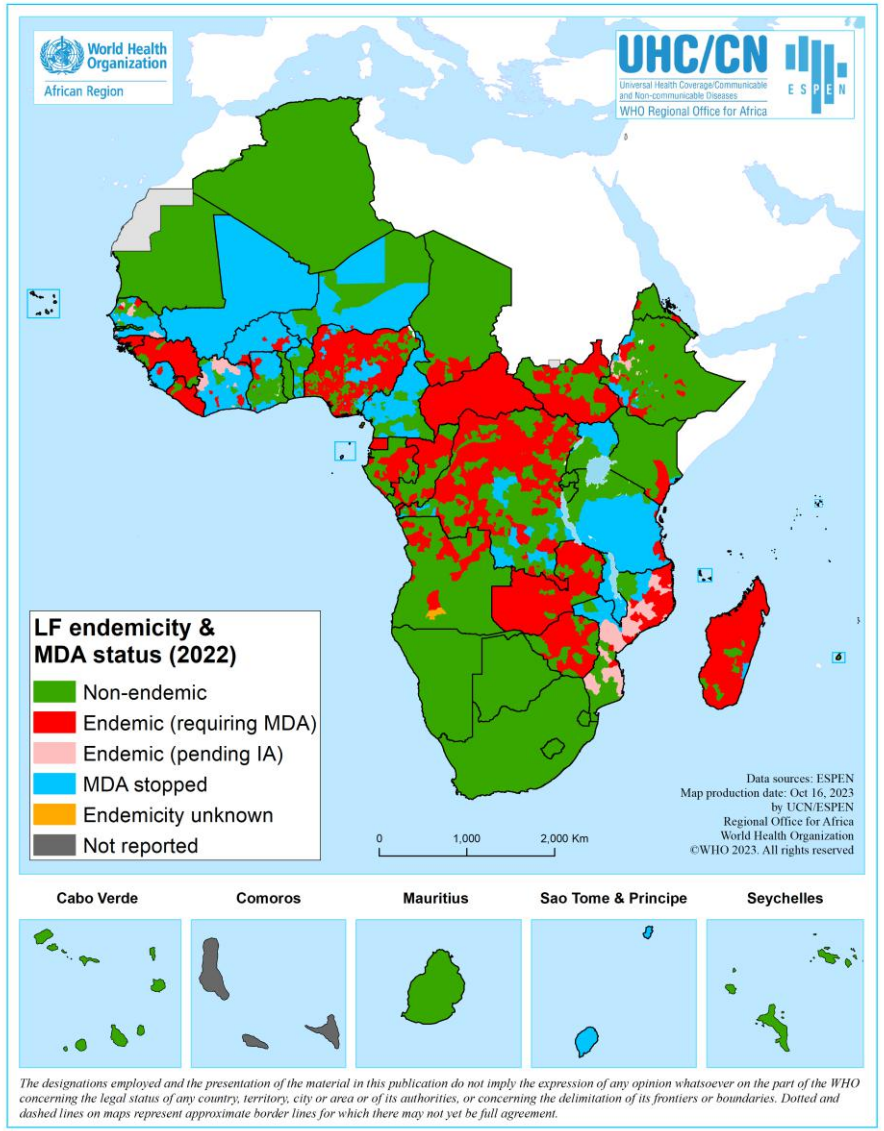
Lymphatic Filariasis – Elimination progress





Lymphatic filariasis PC and Elimination Status in AFRO as of 2023

MDA not started	MDA started but not at scale	MDA scaled to all endemic IUs	MDA stopped in at least one focus	Elimination as Public Health Problem
Gabon	Angola Central African Republic Madagascar	Chad Equatorial Guinea Guinea Guinea Bissau Liberia Sierra Leone South Sudan Zambia Zimbabwe	Benin Burkina Faso Cameroon Comoros Côte d'Ivoire Congo DR Congo Ethiopia Eritrea Ghana Kenya Mali Mozambique Niger Nigeria Senegal Sao Tome and Principe United Rep. of Tanzania Uganda	 Togo (2017) Malawi (2020)
1 (3%)	3 (9%)	9(26%)	19 (56%)	2 (6%)

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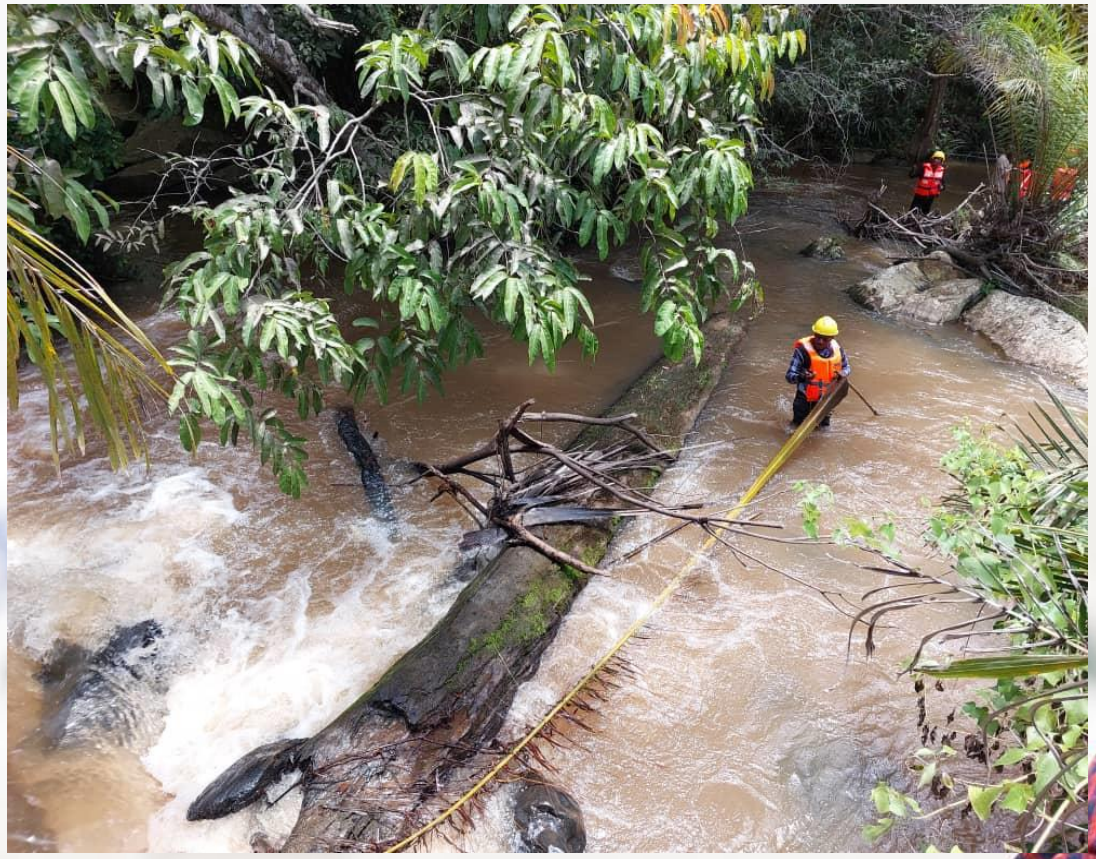
Lymphatic Filariasis – Priorities areas for coming years

- Scaling up Impact assessments and down MDA in areas that have gone through the required number of MDA rounds.
- Integration of passive surveillance in the routine health systems.
- Efficient detection of resilient transmission hotspots.
- Health services provided to ALL individuals affected by LF related morbidity (MMDP systems in place).
- Accelerating dossier elimination submission.

Onchocerciasis



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Onchocerciasis – Background

- Disease caused by the infection with *Onchocerca volvulus*
- Infection transmitted through repeated bites of infective *Simulium* blackflies
- Currently endemic in 32 countries (2 in PAHO, 2 in EMRO and 28 in AFRO)
- Targeted for elimination of transmission
  - Infection in children 5- 9 years below 0.1% (Serology)
  - Infection in *Simulium* blackflies below 0.05% (PCR)

- Core strategic interventions
  - Preventive chemotherapy (IVM)
  - Vector control :
    - Safe spraying of insecticides at blackflies' habitat and larval breeding sites, Slash and clear
  - Case management
    - IVM to manage symptoms
    - Doxy for cure in appropriate circumstances
    - Management of visual impairments

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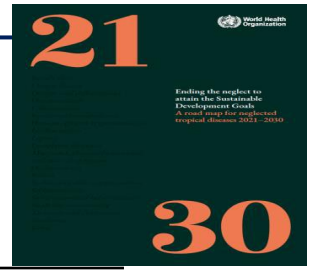
2030 target and sub targets for Onchocerciasis

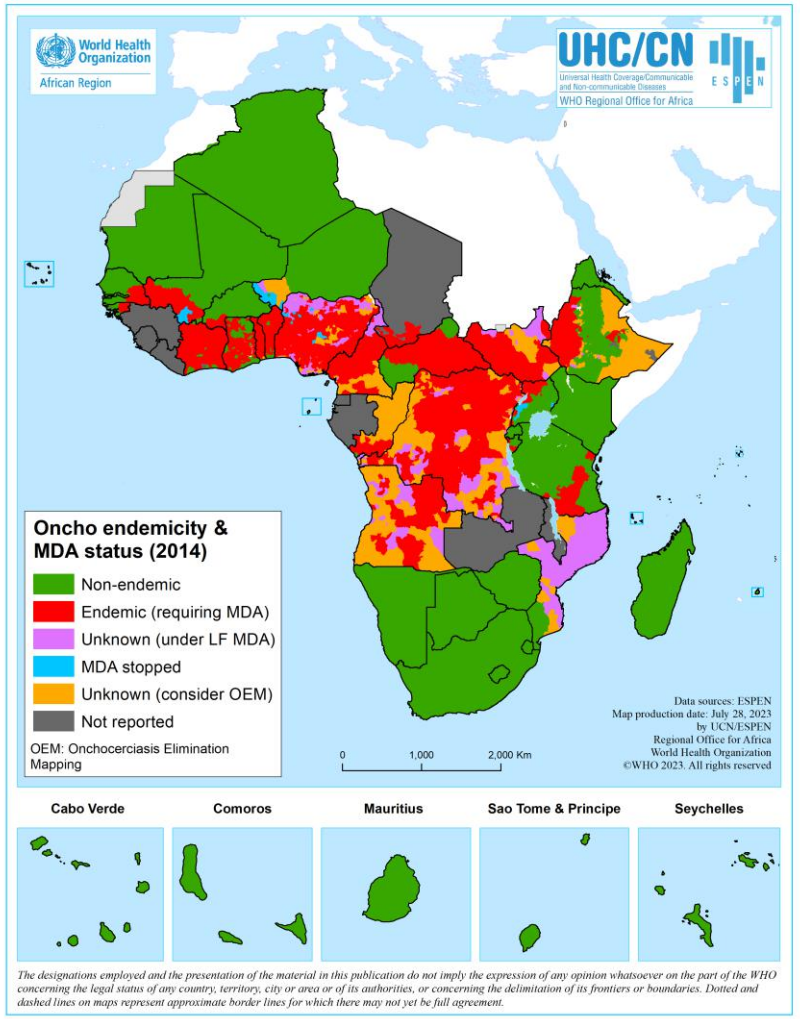


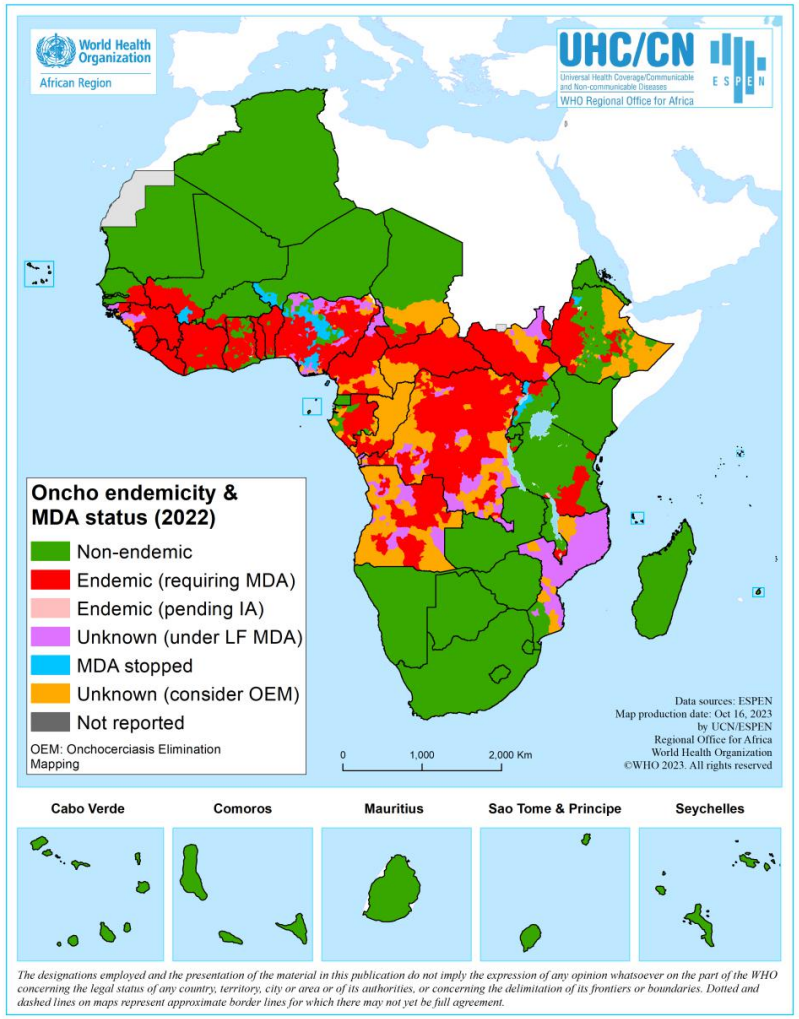
Indicator	2020	2023	2025	2030
Number of countries verified for Interruption of Transmission	**4**	**5**	**8**	**12**
Number of countries that stopped MDA for ≥ 1 focus	9	22	24	**34**
Number of countries that stopped MDA for ≥ 50 % of the population	6	10	25	**> 16**
Number of countries that stopped MDA for 100% of the population	5	6	10	**> 12**

Onchocerciasis – Summaries in AFRO

- 28 endemic countries in the region: 2 pending to start MDA, 3 to scale up MDA to all endemic areas, and 4 scaling down.
- Between 2014 and 2022, over 1.47 billion (1,474,002,723) people received PC for onchocerciasis.
- 243.9M required PC for onchocerciasis in 2022
- Population no longer needing preventive chemotherapy increased from 7.8M in 2016 to 29.4M in 2022
- Endemicity yet to be clarified in Kenya (western), Rwanda and Zambia.
- 195 endemic areas (implementation units) under post-MDA surveillance in 2022 from 22 in 2014.
- Transmission interrupted in Bioko island (Eq. Guinea) and some foci in Ethiopia, Nigeria, Togo, Senegal and Uganda.
- Niger has submitted its elimination dossier.

Onchocerciasis – Endemicity



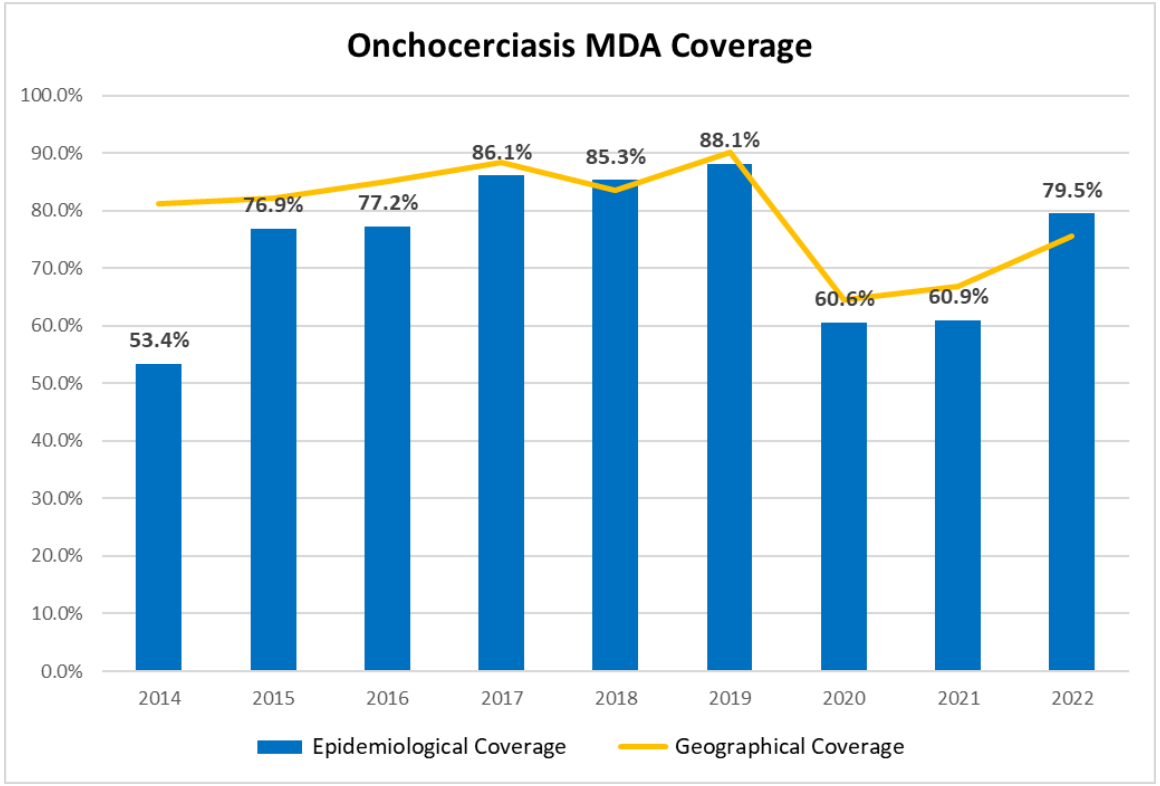


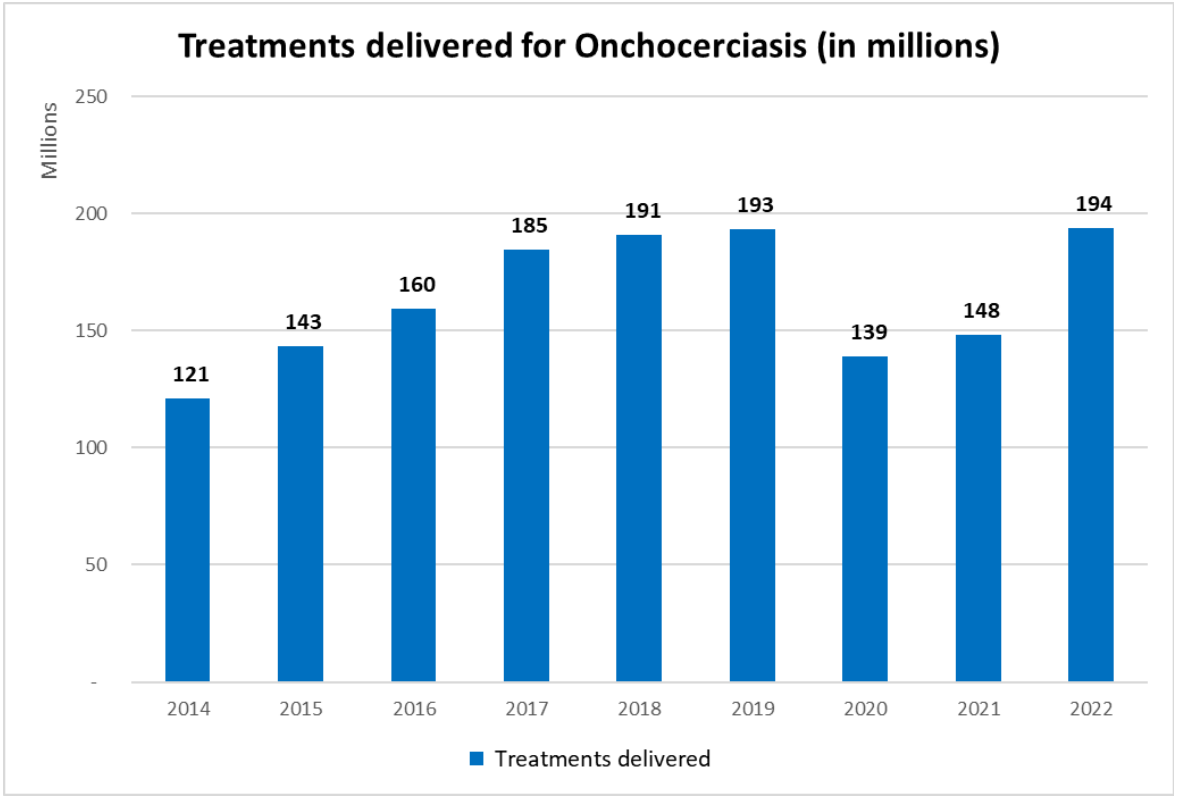
MDA needed in 27 Countries

- 17 countries implementing MDA to country scale.
- 3 countries implementing MDA though not to scale: *Angola, CAR and Eq. Guinea**.
- 5 Countries in the process of scaling down: *Ethiopia, Nigeria, Senegal, Togo and Uganda.*
- 2 countries have not started MDA (Gabon & Mozambique)

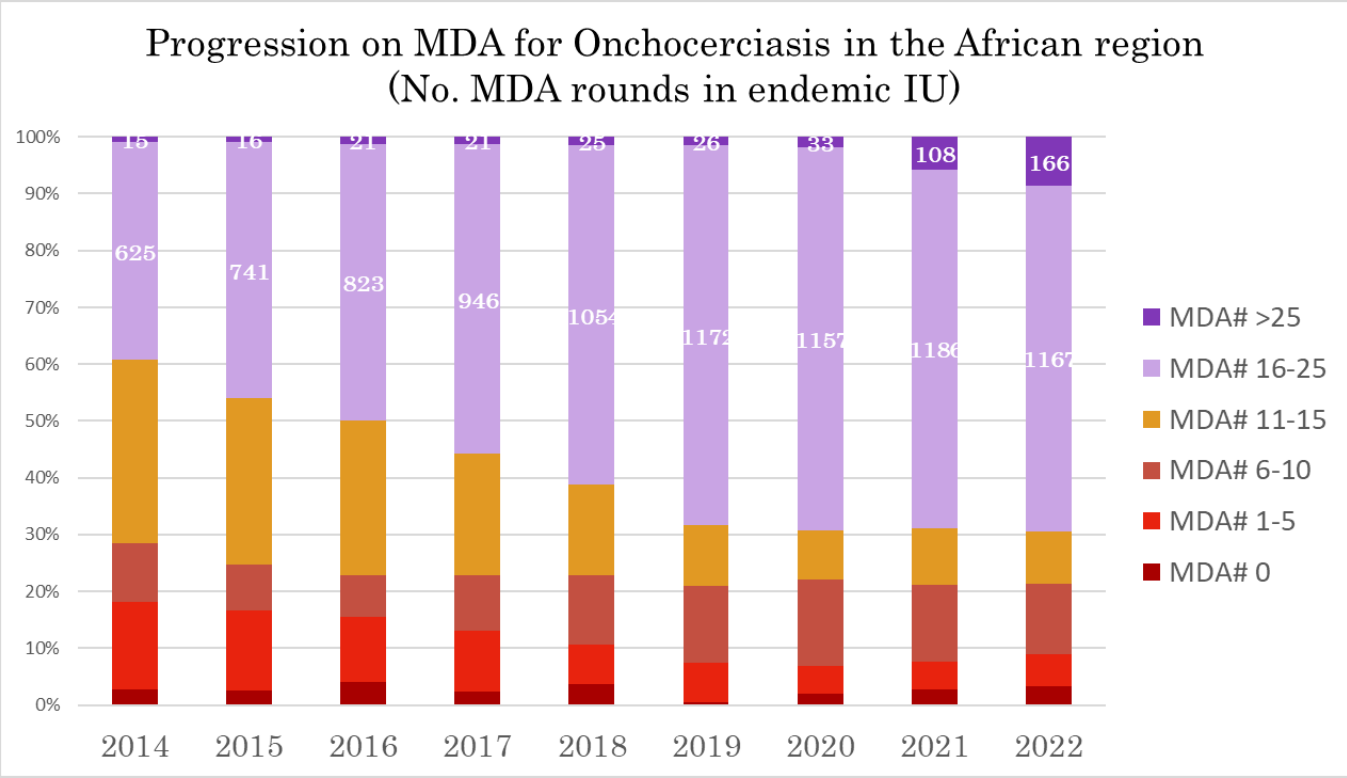
**Transmission likely interrupted in Bioko island and thought limited to some pockets in mainland region.*

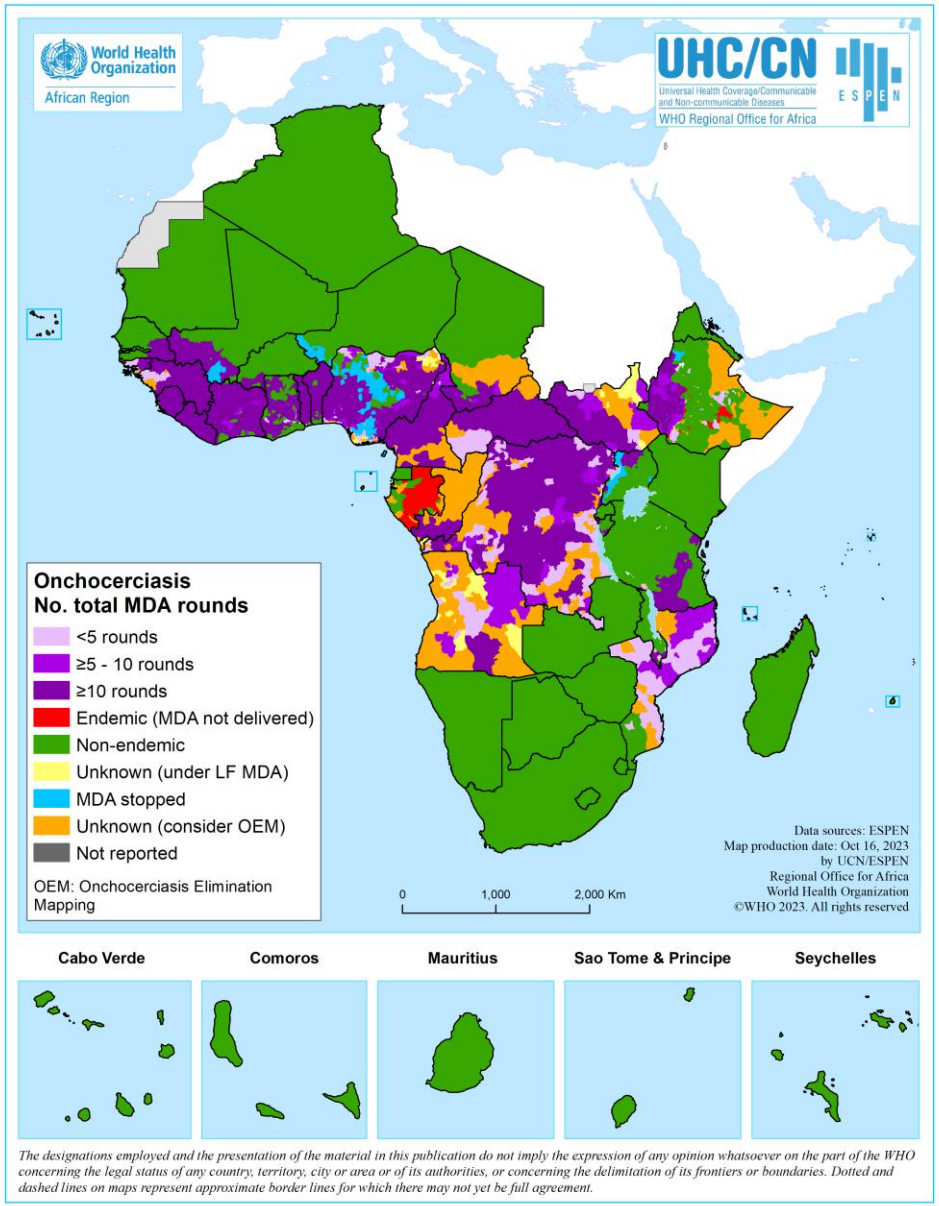
Onchocerciasis – MDA delivered



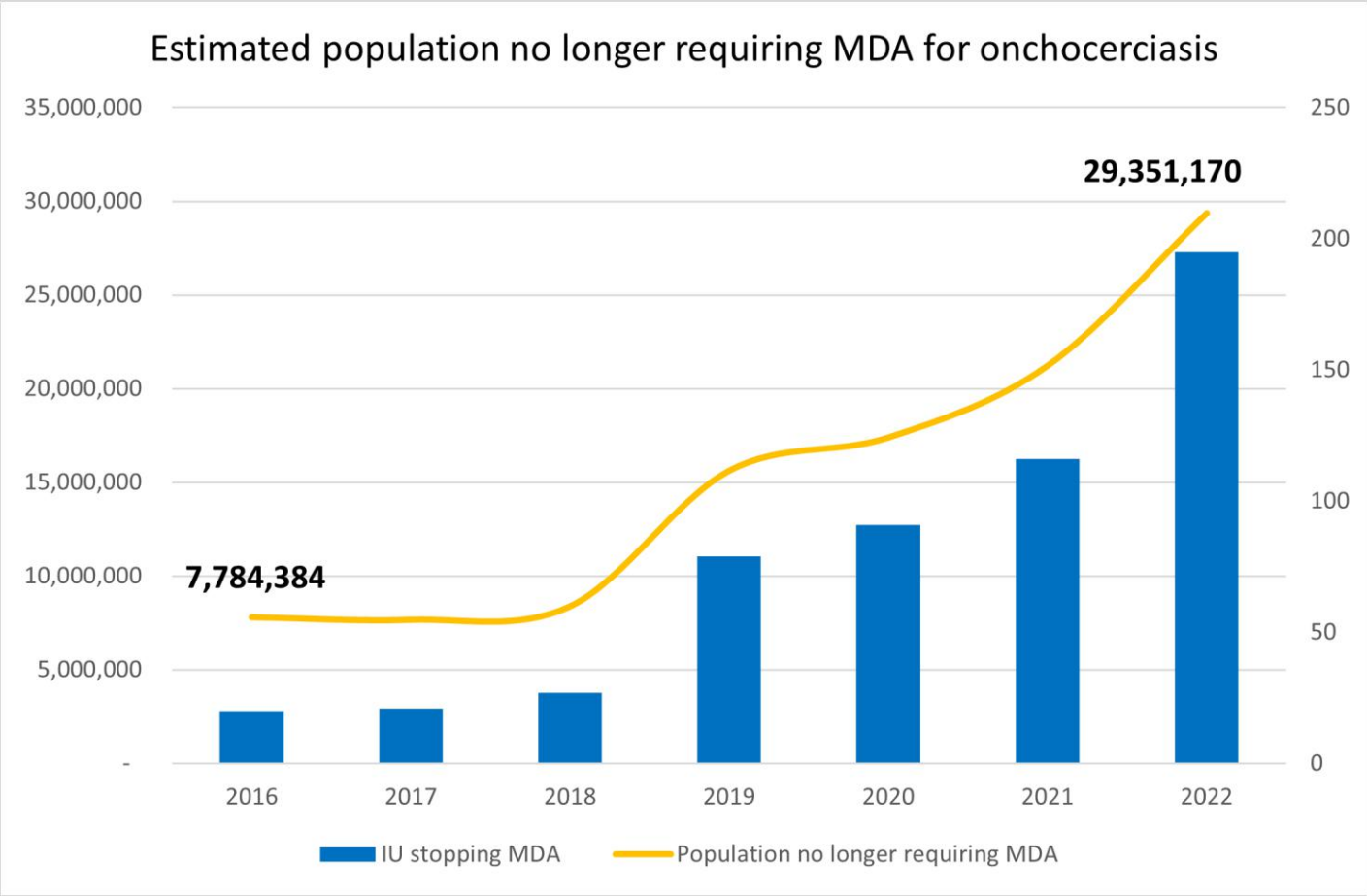


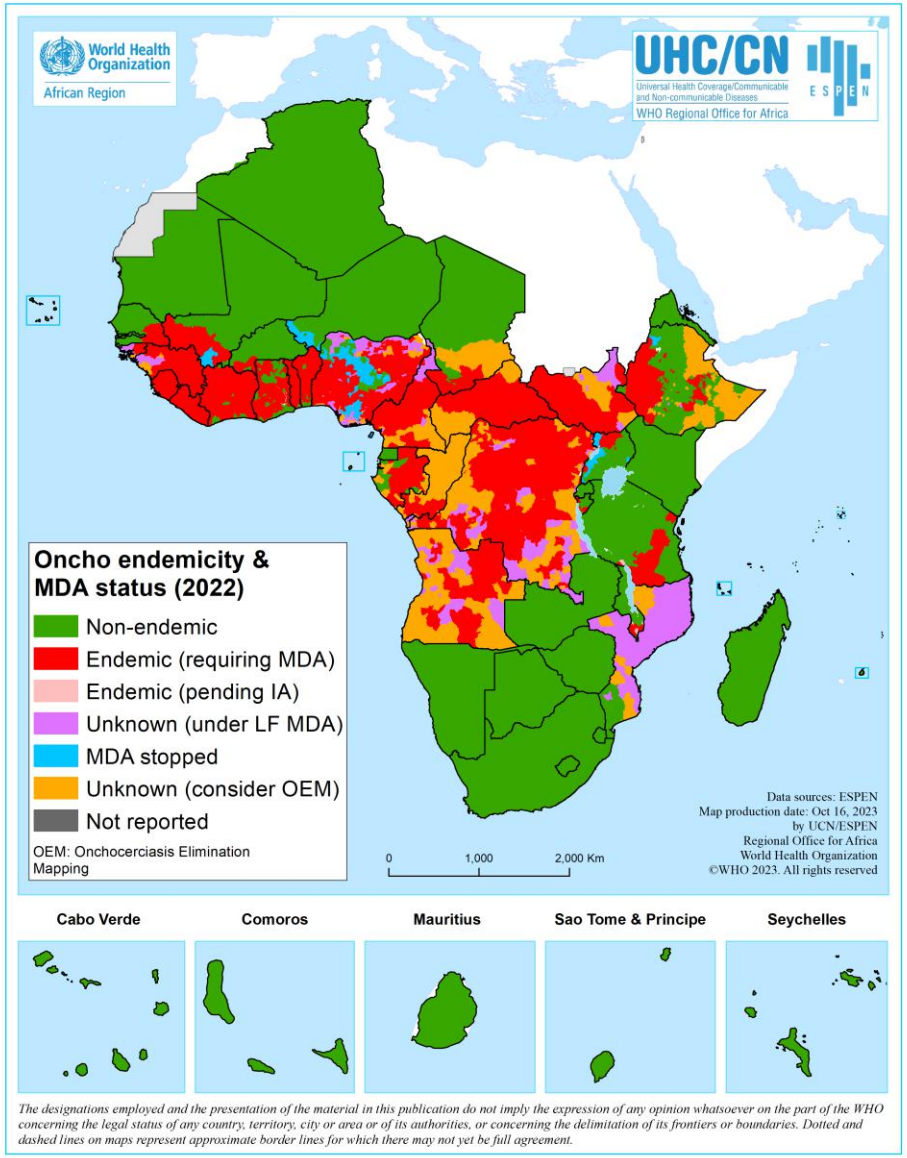
Onchocerciasis – MDA progress





Onchocerciasis – Elimination progress





Onchocerciasis PC Implementation and Elimination Status in AFRO as of 2023

MDA not started	MDA started but not at scale	MDA scaled to all endemic IUs	MDA stopped in at least one focus	Elimination of Transmission Verified
Gabon Kenya+ Rwanda+ Zambia+ Mozambique	Angola CAR Eq. Guinea	Benin Burkina Faso Burundi Cameroon Chad Côte d'Ivoire Congo DR Congo Ghana Guinea Guinea Bissau Liberia Mali Malawi Sierra Leone South Sudan United Rep. of Tanzania	Ethiopia* Nigeria* Senegal* Uganda* Togo*	 None *(Niger – elimination dossier under review)*
5 (16%)	3 (10%)	17 (55%)	5 (16%)	0

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+Not though to need MDA unless OEM identifies

* PTS already started of completed in at least one focus as of now

Onchocerciasis – Priority areas for coming years

- Scaling up impact assessment and “stop-MDA” surveys and scaling down MDA in areas that have gone through more than 15 effective MDA rounds.
- Verification of endemicity status still pending in 638 areas naïve for ivermectin MDA and 523 that have gone through LF MDA.
- Ensuring coordinated actions in transborder foci.
- Accelerating dossier elimination submission.

Achievements

- Lymphatic Filariasis
  - 2 countries validated for Elimination – *Malawi & Togo*
  - 19 countries stopped MDA in at least one IU out of which 7 stopped nationwide (*Benin, Cameroon, Comoros, Eritrea, Mali, STP and Uganda)*

- Onchocerciasis
  - *Niger* has submitted elimination dossier
  - *Senegal* has stopped MDA for oncho in all endemic areas
  - *Uganda* has stopped MDA for more than 50% population requiring PC
  - *Eq Guinea*, *Ethiopia, Nigeria, Togo* have stopped MDA in at least one focus

Thank you

For more information, please contact:

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Medical Officer LF/Onchocerciasis

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Lunch Break (60 min)

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Session 4a: Challenges affecting progress – Schistosomiasis & STH

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Challenges affecting progress: Schistosomiasis

Dr Pauline Mwinzi - ESPEN

Technical Officer SCH/STH

Dr Amadou Garba – WHO/HQ

Medical Officer SCH

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Challenges affecting progress – Schistosomiasis

1. Community level schistosomiasis data, planning and implementation
2. Progress in treatment rounds and impact assessments for SCH in the Africa Region and NTD roadmap milestones
3. Schistosomiasis programme funding gaps
4. Schistosomiasis and Taeniasis / Cysticercosis co-endemicity
5. Adjustment of treatment frequency and medicine quantities for countries conducting MDA for many years/rounds without Impact assessments

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Challenges affecting progress: Schistosomiasis

1. **Community level schistosomiasis data, planning and implementation**
2. Progress in treatment rounds and impact assessments for SCH in the Africa Region and NTD roadmap milestones
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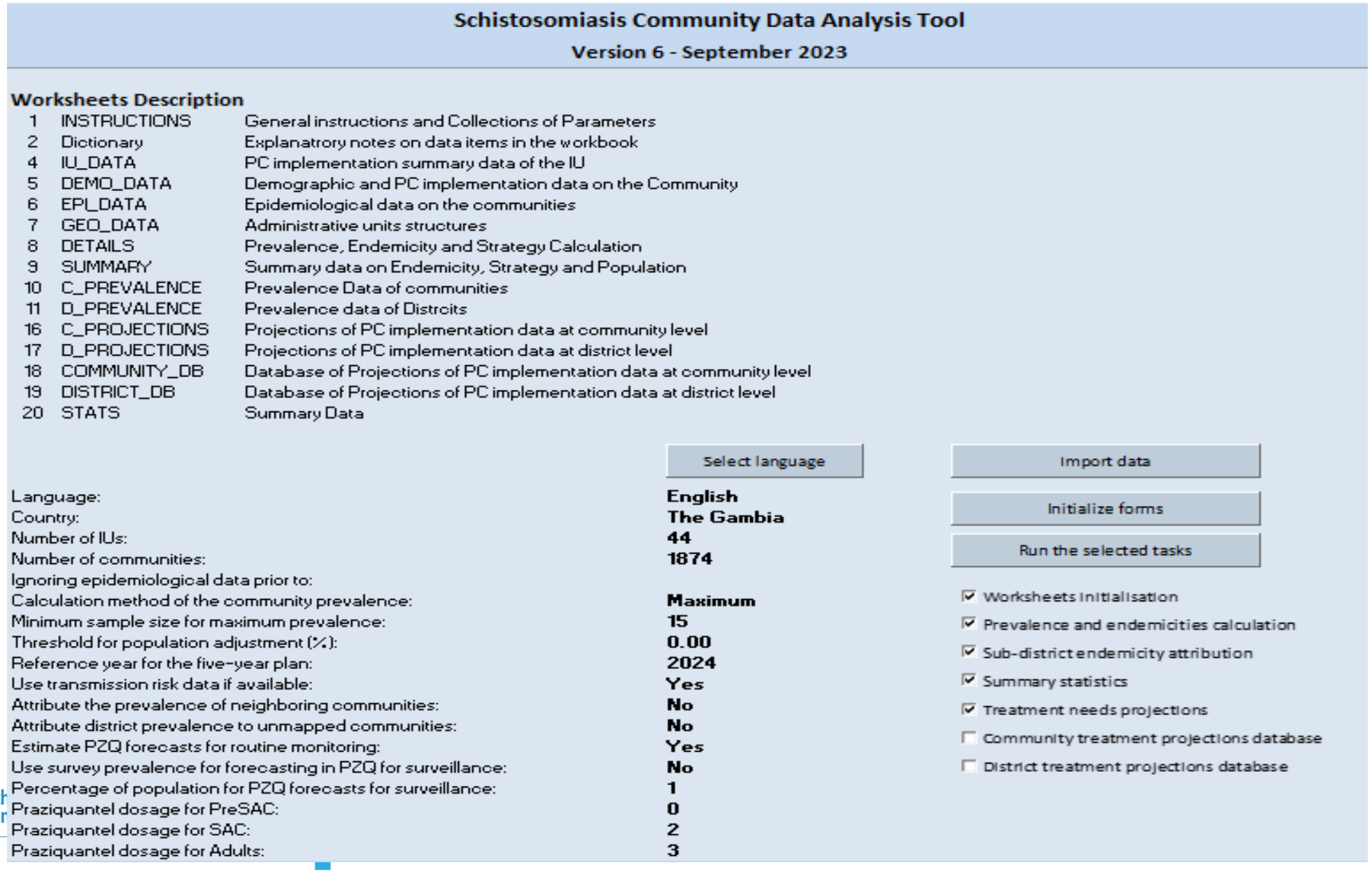
Schistosomiasis community data Workbook Version 6



Schistosomiasis Community Data Analysis Tool

Version 6 - September 2023

Worksheets Description

1	INSTRUCTIONS	General instructions and Collections of Parameters
2	Dictionary	Explanatrory notes on data items in the workbook
4	IU_DATA	PC implementation summary data of the IU
5	DEMO_DATA	Demographic and PC implementation data on the Community
6	EPI_DATA	Epidemiological data on the communities
7	GEO_DATA	Administrative units structures
8	DETAILS	Prevalence, Endemicity and Strategy Calculation
9	SUMMARY	Summary data on Endemicity, Strategy and Population
10	C_PREVALENCE	Prevalence Data of communities
11	D_PREVALENCE	Prevalence data of Distrcits
16	C_PROJECTIONS	Projections of PC implementation data at community level
17	D_PROJECTIONS	Projections of PC implementation data at district level
18	COMMUNITY_DB	Database of Projections of PC implementation data at community level
19	DISTRICT_DB	Database of Projections of PC implementation data at district level
20	STATS	Summary Data

Select language | Import data

Language:	**English**
Country:	**The Gambia**
Number of IUs:	**44**
Number of communities:	**1874**
Ignoring epidemiological data prior to:	
Calculation method of the community prevalence:	**Maximum**
Minimum sample size for maximum prevalence:	**15**
Threshold for population adjustment (%):	**0.00**
Reference year for the five-year plan:	**2024**
Use transmission risk data if available:	**Yes**
Attribute the prevalence of neighboring communities:	**No**
Attribute district prevalence to unmapped communities:	**No**
Estimate PZQ forecasts for routine monitoring:	**Yes**
Use survey prevalence for forecasting in PZQ for surveillance:	**No**
Percentage of population for PZQ forecasts for surveillance:	**1**
Praziquantel dosage for PreSAC:	**0**
Praziquantel dosage for SAC:	**2**
Praziquantel dosage for Adults:	**3**

Initialize forms

Run the selected tasks

- [x] Worksheets Initialisation
- [x] Prevalence and endemicities calculation
- [x] Sub-district endemicity attribution
- [x] Summary statistics
- [x] Treatment needs projections
- [ ] Community treatment projections database
- [ ] District treatment projections database

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Use case for SCH community data analysis tool

- Disaggregation of Epi data to community level in line with SCH guideline
- Community level planning for interventions
- Quantification of estimated medicines needed at community level
- Remapping and impact assessment needs
- Treatment strategy change
- Part of JRSM (medicine application form for donated medicine) to refine medicine data
- Monitoring of the progress of the NTD SDG goal (reduction of the number of people requiring intervention (target 90% reduction by 2030)

New features …1

- A single workbook featuring both English and French unlike the previous versions where English and French are separate tool
- Inclusion of additional population age groups:
  - Preschool children
  - Women of reproductive age (15-49 years)
  - Women of reproductive age (15-24 years)
- Population indicators (age group percentages) are harmonised with ESPEN database
- PC History indicators are incorporated from ESPEN Global PC database and Updates from countries (April and May workshops)
- Distinction of survey data into:
  - Baseline
  - Impact
- Community prevalence and endemicity are determined separately for Baseline and Impact
- Treatment strategy is determined according to the new guidelines using baseline and impact prevalence

New features …2

- Community treatment Strategy is based exclusively on community prevalence data if available
- No more attribution of district endemicity to community
- No more attribution of neighbouring community endemicity
- Possibility to use transmission risk assessment data derived from other methods of estimation
  - Environmental data
  - Modelling
  - (must be qualified as no transmission, low, moderate and high transmission)
- Hotspot communities are identified
- Treatments Needs Estimations
  - Number of people to be treated every year is estimated for the 5 age groups
  - Number of PZQ is calculated for each age group according to the treatment strategy
- Possibility to calculate provisional PZQ for communities under surveillance (those with prevalence less than 10% after impact)

New features…3

- Estimations of baseline mapping gaps
  - ✓ Any community without baseline prevalence and without impact assessment
  - ✓ Any community without baseline prevalence and without data on transmission risk
- Estimations of impact assessment gaps
- Number of communities due for Impact assessment:
  - ✓ Community that has baseline prevalence data (low, moderate or high) but did not have any impact data and PC history indicates 5 or more rounds of PC
  - ✓ Community that have no baseline, no impact but being treated

Use of the SCH Community data tool and guidance

5 (33.3%)

10 (66.7%)

Country	WHO Guidelines used for Schisto MDA
Benin	Old (district level implementation)
Burundi	Old (district level implementation)
Cameroun	New (community level implementation)
Congo	Old (district level implementation)
Congo, RDC	New (community level implementation)
Ethiopia	Old (district level implementation)
Guinée Bissau	New (community level implementation)
Malawi	New (community level implementation)
Mauritanie	Old (district level implementation)
Niger	New (community level implementation)
Nigeria	New (community level implementation)
Rwanda	New (community level implementation)
Senegal	New (community level implementation)
Sierra Leone	New (community level implementation)
South Sudan	New (community level implementation)

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RPRG Discussion

Use of the ESPEN schistosomiasis community data analysis tool (now linked to JAP) by the remaining Member States to align with WHO schistosomiasis guidelines on implementing SCH interventions at community level, and increase efficiency in estimation and use of PZQ

Challenges affecting progress: Schistosomiasis

1. Community level schistosomiasis data, planning and implementation
2. **Progress in treatment rounds and impact assessments for SCH in the Africa Region and NTD roadmap milestones**
3. Schistosomiasis programme funding gaps
4. Schistosomiasis and Taeniasis / Cysticercosis co-endemicity
5. Adjustment of treatment frequency and medicine quantities for countries conducting MDA for many years/rounds without Impact assessments

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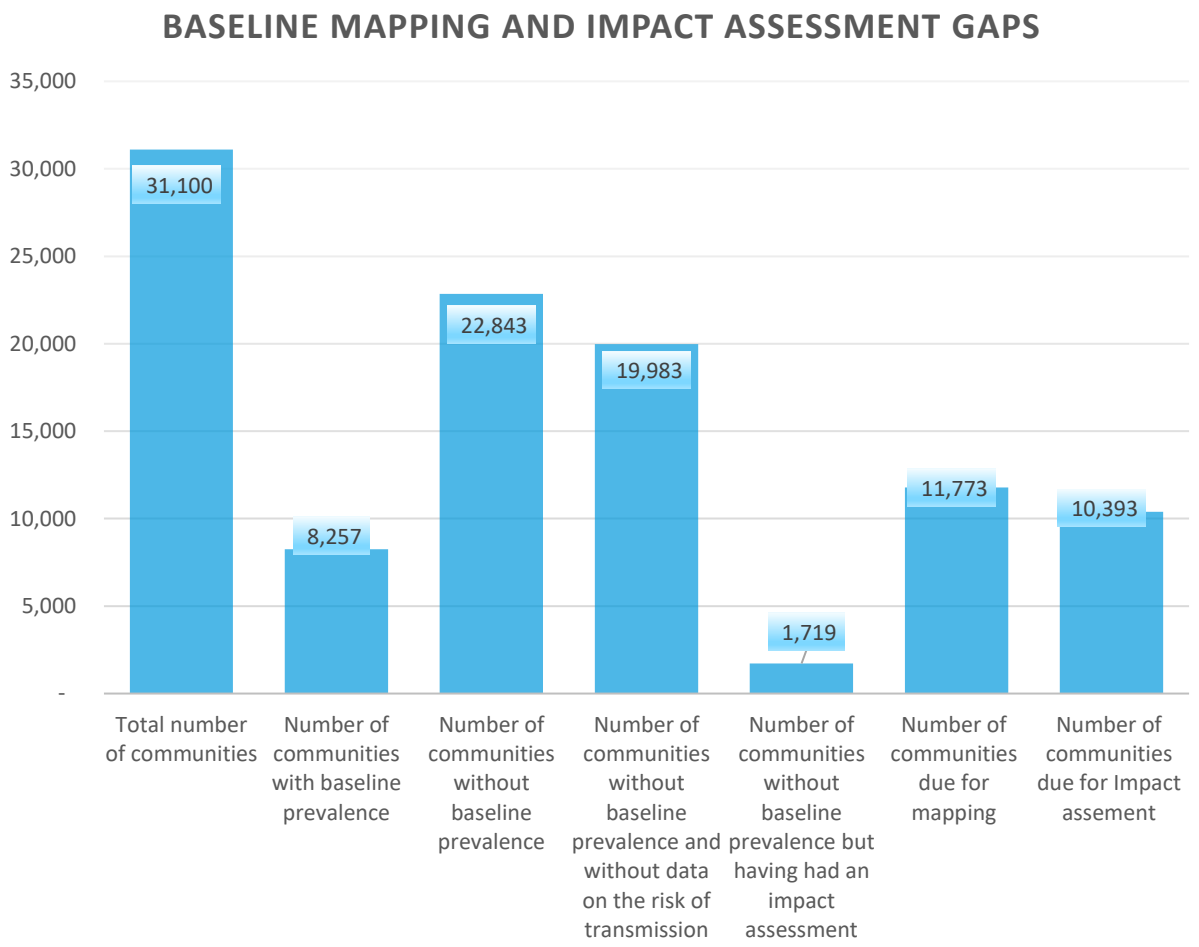
Number of sub-districts due for Impact Assessment

- Methods of calculation
  - Due for mapping
    - ✓No baseline prevalence
    - ✓No impact prevalence
    - ✓No transmission risk data
    - ✓Not yet under PC
  - Due for impact assessment
    - ✓Baseline prevalence is low, moderate or High
    - ✓Under PC (received enough rounds (3 or more) of PC
    - ✓No impact assessment prevalence

Baseline mapping and impact assessment needs

Indicator	Value
Total number of communities	31,100
Number of communities with baseline prevalence	8,257
Number of communities without baseline prevalence	22,843
Number of communities without baseline prevalence and without data on the risk of transmission	19,983
Number of communities without baseline prevalence but having had an impact assessment	1,719
Number of communities due for mapping	11,773
Number of communities due for Impact assement	10,393



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Number of sub-districts due for Impact Assessment

Country	Total number of communities	Number of communities with baseline prevalence	Number of communities without baseline prevalence	Number of communities without baseline prevalence but having had an impact assessment	Number of communities due for mapping	Number of communities due for Impact assessment
Benin	546	252	294	30	239	43
Botswana	522	70	452	0	452	0
Burkina Faso	2,102	103	1,999	88	0	1,973
Burundi	129	68	61	60	0	3
Cameroun	1,766	333	1,433	236	732	574
Congo	424	79	345	0	294	60
Côte d'Ivoire	2,253	644	1,609	0	1,549	65
eSwatini	281	140	141	0	141	0
Ethiopia	17,362	1,812	15,550	4,110	9,650	1,902
Gabon	230	117	113	0	113	0
Guinea	383	118	265	5	148	156
Guinée-Bissau	117	45	72	0	72	0
Kenya	1,450	723	727	20	707	0
Liberia	82	62	20	0	15	12

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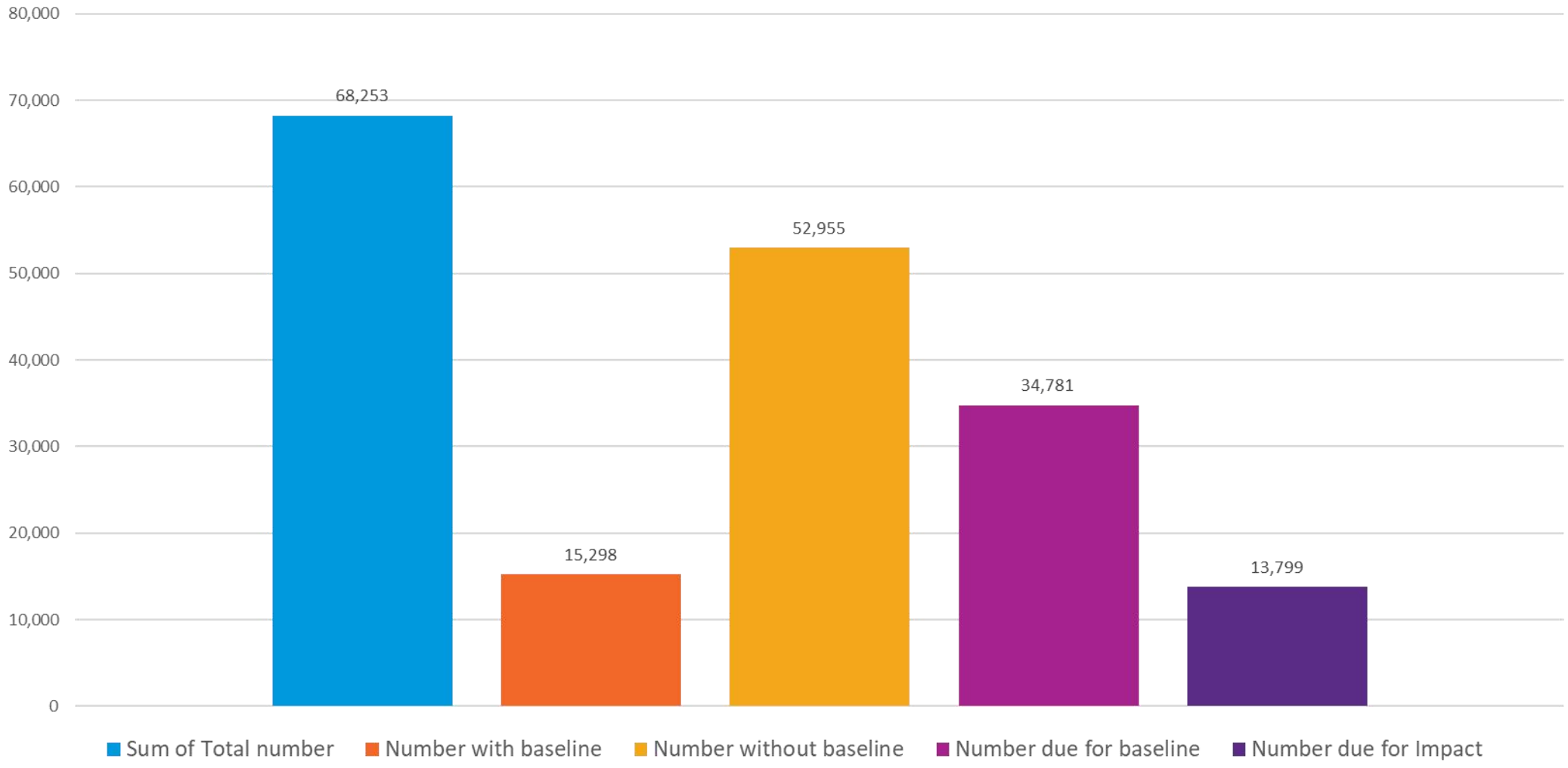
Number of sub-districts due for Impact Assessment

Country	Total number of communities	Number of communities with baseline prevalence	Number of communities without baseline prevalence	Number of communities without baseline prevalence but having had an impact assessment	Number of communities due for mapping	Number of communities due for Impact assessment
Madagascar	1,622	171	1,451	0	886	657
Malawi	433	250	183	16	0	265
Mali	1,510	174	1,336	60	0	1,146
Mauritanie	220	45	175	0	128	52
Mozambique	1,633	771	862	0	468	783
Namibia	113	97	16	0	16	0
Niger	1,088	53	1,035	337	17	690
Nigeria	9,684	3,352	6,332	4	5,625	1,055
RDC	9,377	1,409	7,968	0	7,715	313
Sénégal	1,610	86	1,524	187	0	764
Sierra Leone	194	73	121	0	70	99
South Africa	213	56	157	0	157	0
South Sudan	516	278	238	0	238	0
Tanzania (Mainland)	4,223	2,194	2,029	555	786	1,413
Tanzania (Zanzibar)	331	122	209	0	209	0
Tchad	1,845	259	1,586	0	1,452	150
The Gambia	1,874	150	1,724	0	1,724	0
Togo	730	468	262	79	18	168
Zambia	1,421	469	952	2	950	0
Zimbabwe	1,969	255	1,714	123	210	1,456

Number of sub-districts due for Impact Assessment



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SCH: Countries that have conducted MDAs for over 5 years, have conducted impact assessment

Country	number of treatment rounds Max-Min	number of effective treatment	Survey	
			Year	Baseline (Number of sites)
Burundi	1-12	1-12	2007	107
Benin	0-8	0-7	2013	34
Burkina Faso	6-10	6-10	1997	23
Côte d'Ivoire	1-7	0-6	2012	948
Cameroun	0-11	0-11	2012	810
RDC	0-8	1-7	2010	80
Mali	2-16	2-16	2004	183
Niger	0-16	0-16	1974	13
Sénégal	0-11	0-11	1996	4
Liberia	0-5	1-5	1979	40
Malawi	4-8	3-7	2012	534
Tanzania (Mainland)	1-9	1-7	1978	15
Zimbabwe	0-7	0-7	1992	2

RPRG Discussion

1. As programmes countries have made progress in implementation large scale PC for schistosomiasis, some with more than 16 rounds of MDA, RPRG to encourage countries to undertake impact assessment in order to show progress and attainment of the EPHP target and milestones set in the NTD roadmap.

2. Absence of SCH infection in human population is the NTD roadmap second target for SCH transmission interruption. Three countries are concerned in the Region (Mauritius, Sao Tome, Algeria).
These countries are encouraged to starting surveys to demonstrate this achievement according to WHO guidelines.

Challenges affecting progress: Schistosomiasis

1. Community level schistosomiasis data, planning and implementation
2. Progress in treatment rounds and impact assessments for SCH in the Africa Region and NTD roadmap milestones
3. **Schistosomiasis programme funding gaps**
4. Schistosomiasis and Taeniasis / Cysticercosis co-endemicity
5. Adjustment of treatment frequency and medicine quantities for countries conducting MDA for many years/rounds without Impact assessments

Status of MDA implementation in 2023

Implemented at least 1 round

Country	Completed all rounds		Planned month of last MDA
	Yes	No	
Benin	1		
Burundi		1	Novembre 2023
Cameroun	1		
Congo		1	Decembre 2023
Congo, RDC		1	Decembre 2023
Eswatini		1	Janvier 2024
Ethiopia		1	Decembre 2023
Ghana		1	Novembre 2023
Guinée Bissau		1	Novembre 2023
Guinée Equatoriale		1	Novembre 2023
Malawi		1	Novembre 2023
Mauritanie		1	Octobre 2023
Niger	1		
Nigeria	1		
Rwanda		1	Novembre 2023
Senegal		1	Decembre 2023
Sierra Leone		1	Novembre 2023
South Sudan		1	Decembre 2023
Grand Total	**4**	**14**	

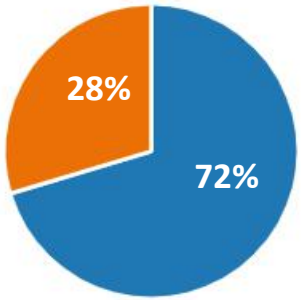
Did not start yet

Country	Reason of MDA not started
Botswana	Late arrival of medicines
Comores	Not planned MDA in 2023
Eritrea	Fund transferred to MoH in October 2019.;
Gambia	Insufficient funding
STP	MDA planned in December 2023 Waiting forward to receiving funding
South Africa	Insufficiant funding Tenical capacity in implementation
Zimbabwe	Still waiting for medicines to arrive s treatment may commence

Status of implementation of 2023 MDA

MDA implemented

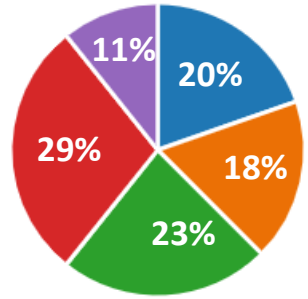
Oui	18
Non	7



5. Si OUI, quelles maladies ont été ciblées en 2023?

Plus de détails

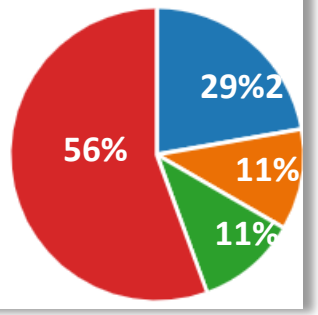
Filariose lymphatique	11
Onchocercose	10
Géohelminthiases	13
Schistosomiase	16
Trachome	6



6. Si NON, pourquoi?

Plus de détails

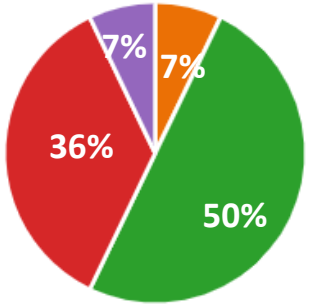
Insuffisance de financement	2
Arrivée tardive des médicaments	1
Capacité technique dans la mise...	1
Autre	5



8. Si NON, en quel mois est prévu la dernière tournée de traitement pour 2023?

Plus de détails

Septembre 2023	0
Octobre 2023	1
Novembre 2023	7
Decembre 2023	5
Janvier 2024	1



African Region

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PC: Countries lagging behind

South Africa: progress in preparation for SCH PC

- MCAT is now in place in south Africa
- National SCH/STH committee has been established, TOR.
- Developed planning documents and tools
- MDA has been postponed to 2024
  - Budget was not adequate
  - Inadequate HR at department of education
  - Co-endemicity with taeniasis in targeted regional of Eastern Cape
  - Pilot MDA will be moved to KZN

Equatorial Guinea: partnership for SCH PC

- ESPEN has discussed partnership with Spanish Foundation
- Discussions are ongoing
- MDA plan and budget for the two endemic districts where data is available
- Further mapping to be conducted by the Spanish Foundation
- MDA to be supported by ESPEN in 2024

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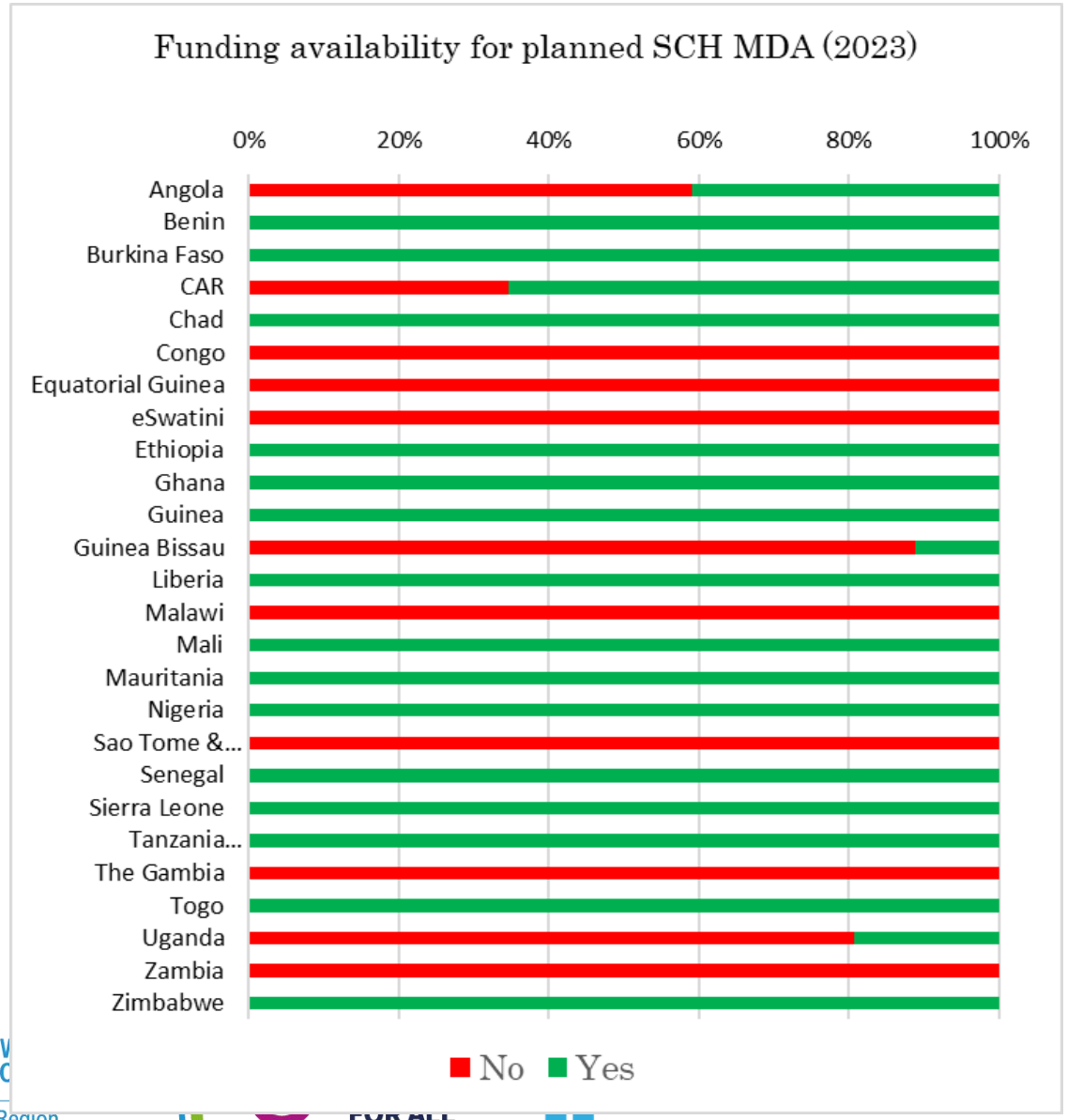
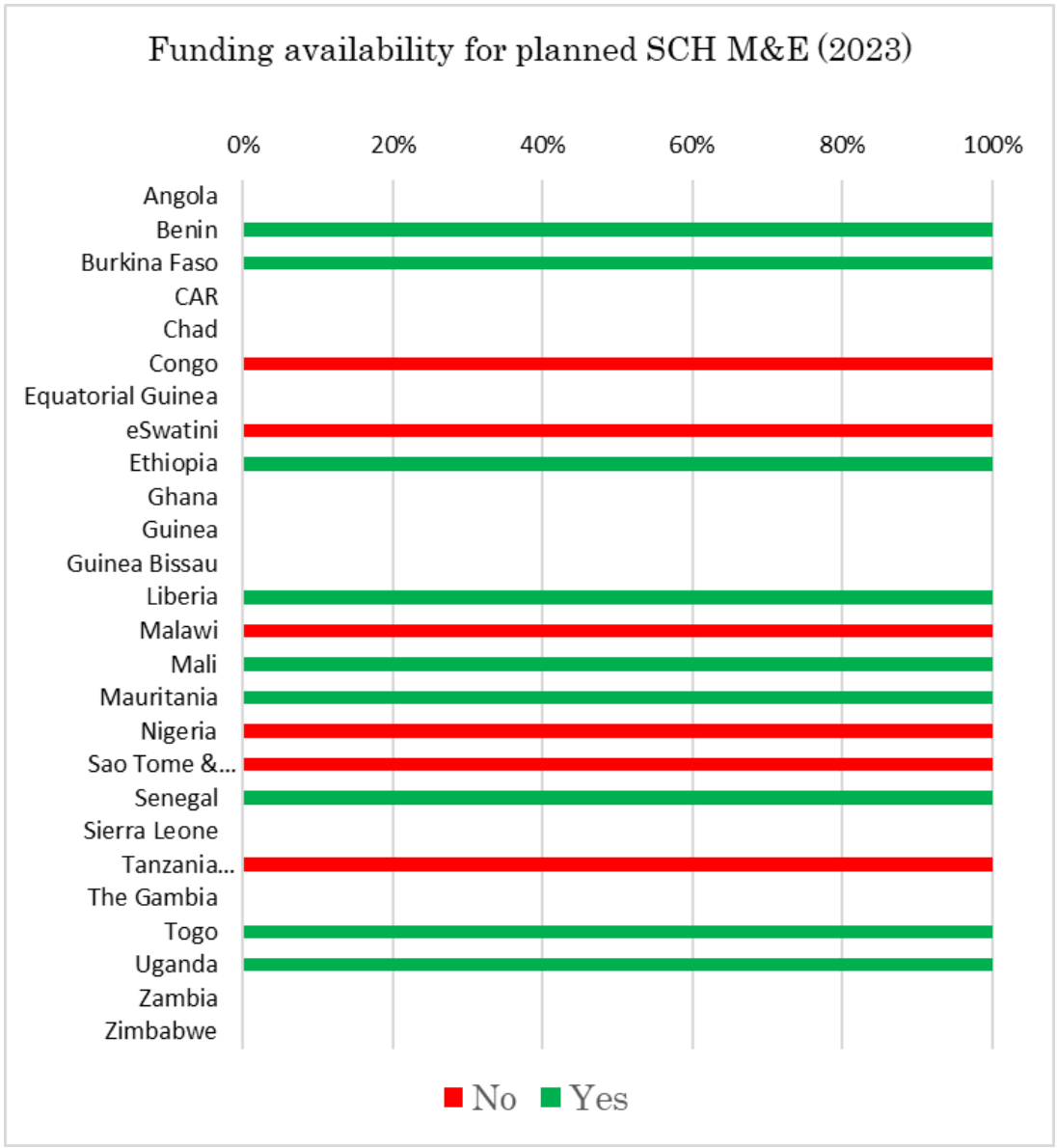
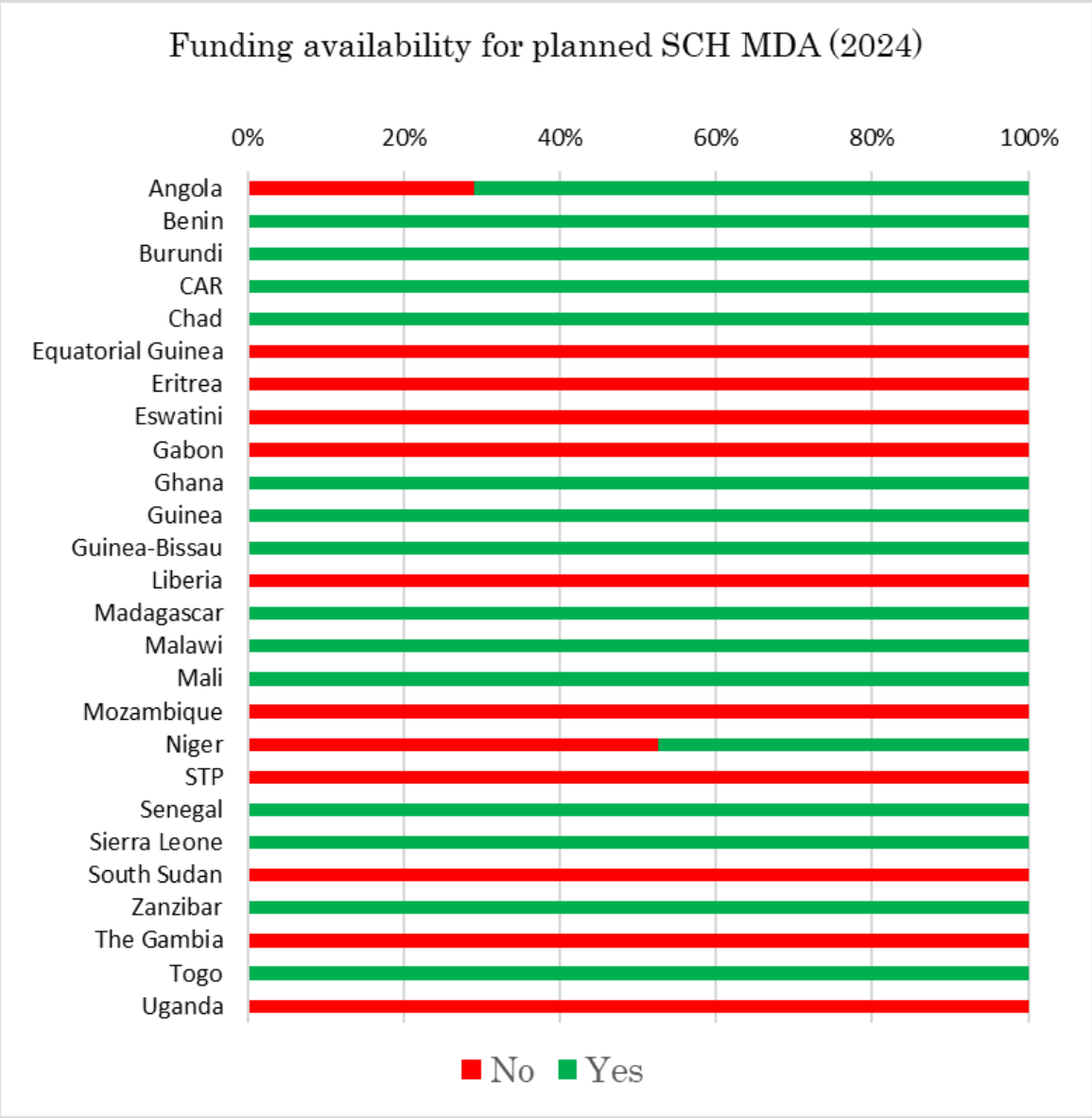
Potential Funding Gaps 2023

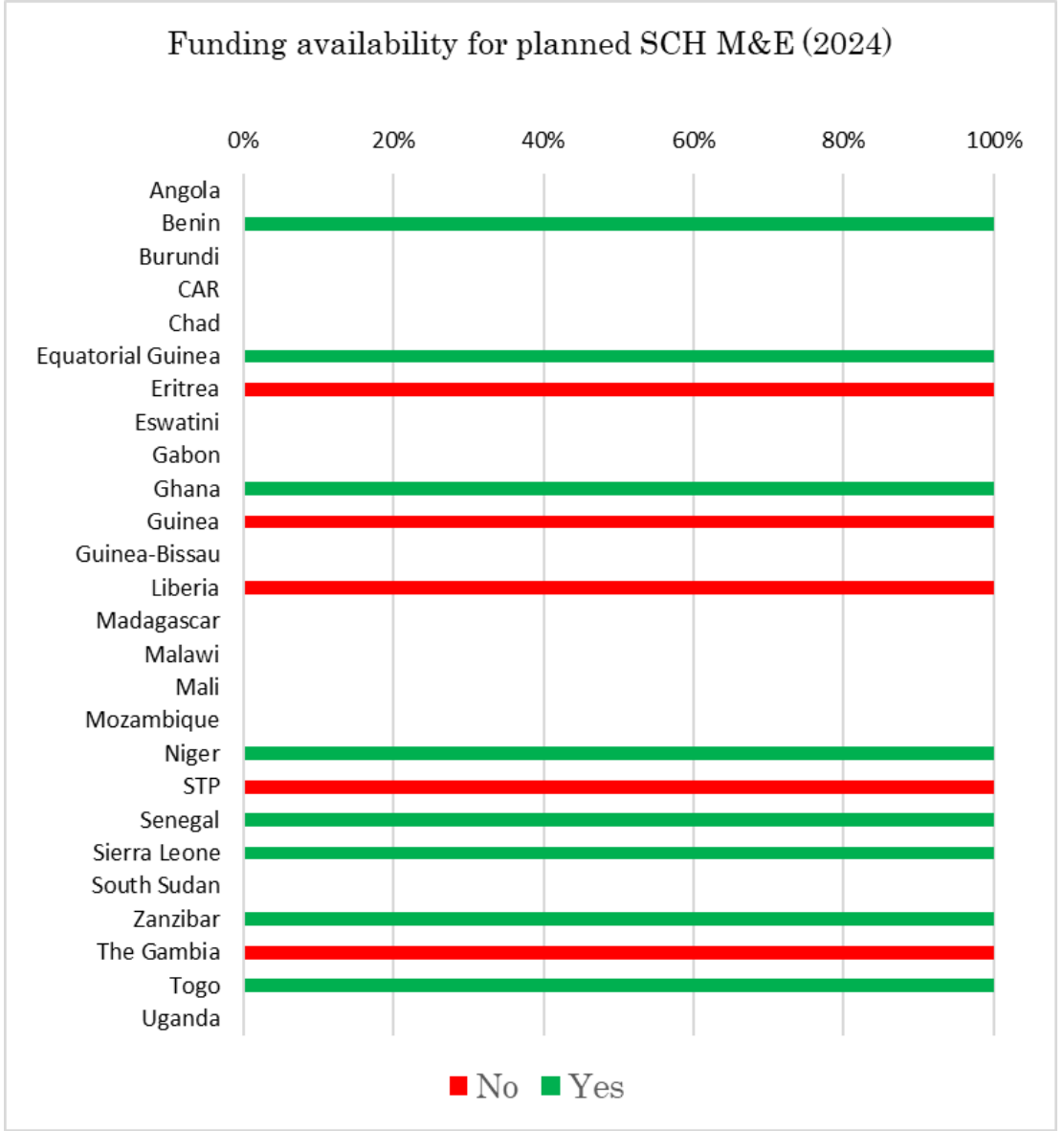




African Region

Potential Funding Gaps 2024





African Region

SCH/STH funding gaps

	2023 (26 countries)		2024 (25 countries)	
	Funding needed	Funding secured	Funding needed	Funding secured
Population requiring PC for SCH/STH	58,733,527	170,010,170	66,043,091	171,067,288
Cost estimate PC for SCH/STH	$ 29,366,628.50	$ 85,005,085.00	$ 33,021,545.50	$ 85,533,644.00

**assuming average cost of US $ 0.5 per person treated (Solari et al. PLoS Negl Trop Dis. 2020 Mar; 14(3): e0008098.*

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RPRG discussion (3)

- Over 25% of the implementation units reporting data have allegedly not secured funding to cover the planned PC interventions for schistosomiasis in 2024.
- Over 91M people in 26 countries and 94M people in 22 countries are at risk of not receiving the needed PC interventions in 2023 and 2024, respectively, based on the reports received so far.
- Countries with MDA funding gaps 2023, 2024: Gambia, Congo, Eswatini, Eritrea, STP, Equitorial Guinea, South Africa, Liberia, Malawi, Zambia.
  - Political commitment and country ownership and financing to cover MDA and M&E gaps
  - Resource mobilization advocacy
  - Call for Equatorial Guinee and South Africa to start and scale up PC for schistosomiasis and progress towards SDG and NTD roadmap targets

Challenges affecting progress: Schistosomiasis

1. Community level schistosomiasis data, planning and implementation
2. Progress in treatment rounds and impact assessments for SCH in the Africa Region and NTD roadmap milestones
3. Schistosomiasis programme funding gaps
4. **Schistosomiasis and Taeniasis / Cysticercosis co-endemicity**
5. Adjustment of treatment frequency and medicine quantities for countries conducting MDA for many years/rounds without Impact assessments

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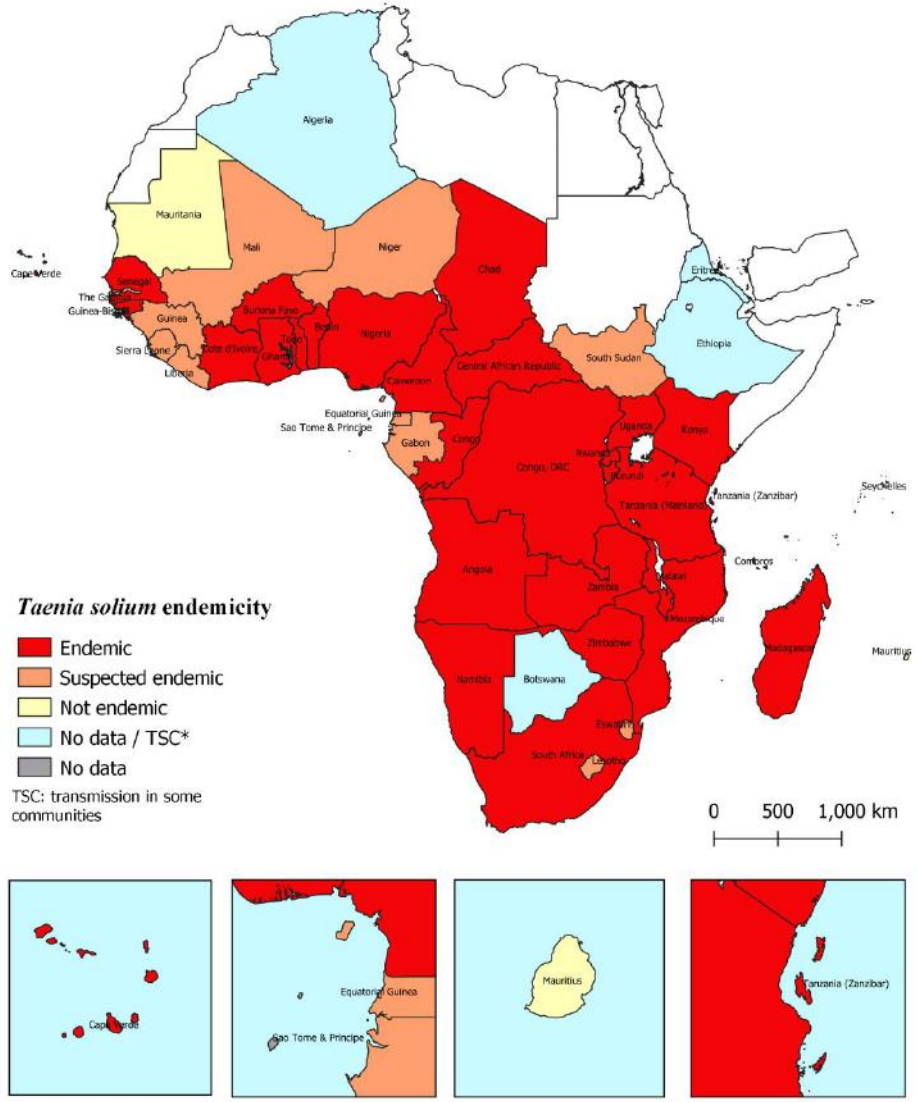
Taeniasis / Cysticercosis

- 27 endemic countries and 11 suspected endemic.
- Caused by the pork tapeworm *Taenia solium and t*ransmitted by consumption of undercooked infected pork or self infection
- Adult worm is mostly asymptomatic, larval forms however migrate through out the body causing cysticercosis
- In the central nervous system of humans (neurocysticercosis) is a significant cause of epilepsy (up to 70% in some places) and other neurological conditions
- MDA for schistosomiasis can cause serious effects or death in those with cysticercosis unless co-treatment is given
- First integrated MDA with praziquantel, niclosamide and albendazole conducted in Zambia - 300,000 persons, and is planned for Madagascar.

Progress:

- Training resources for control launched in OpenWHO in November 2023
- Evaluation framework to be launched in 2023



RPRG discussion: MDA in areas co-endemic for SCH/T.sol (4)

- *T. solium* mapping activities for sub-national stratification
- Research and development for diagnostics
- Development and implementation of One Health approach
- Training of NTD Programmes on safety of administering PZQ, ALB, Niclosamide medicines (including using the resources in OpenWHO)
- Active safety monitoring system and communication plan when distributing PZQ in areas co-endemic for SCH and Teniasis.
- Countries to fill out separate JRSM for PZQ and niclosamide request from Bayer through WHO

Challenges affecting progress: Schistosomiasis

1. Community level schistosomiasis data, planning and implementation
2. Progress in treatment rounds and impact assessments for SCH in the Africa Region and NTD roadmap milestones
3. Schistosomiasis programme funding gaps
4. Schistosomiasis and Taeniasis / Cysticercosis co-endemicity
5. **Adjustment of treatment frequency and medicine quantities for countries conducting MDA for many years/rounds without Impact assessments**

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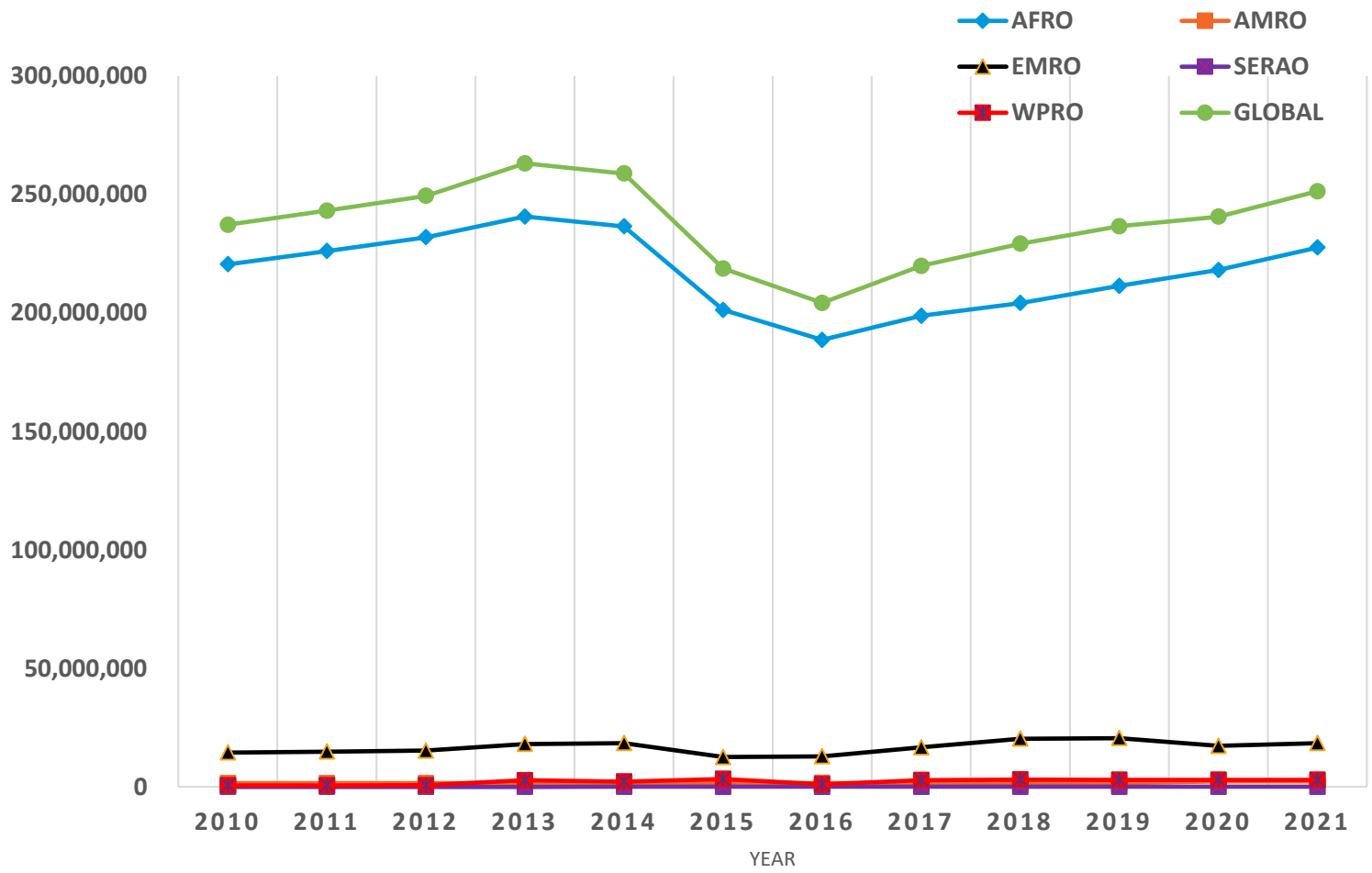
Update

- The number of people requiring PC for schistosomiasis keeps increasing despite the impact of PC (251 M in 2021, 264 M in 2022)
- Monitoring need of the reduction of the number of people requiring intervention for NTD (SDG/NTD indicator; 90% reduction target for 2023)
- The number of people requiring preventive chemotherapy for schistosomiasis should be reflecting the impact achieved and the new schistosomiasis guideline, for more efficient management of the donation of praziquantel.
- More than 2 Billion tablets of praziquantel have been distributed in the African region 2012 to 2022
- A draft SCH /STH MDA framework is in final stages of approval

Number of people requiring PC for schistosomiasis 2010-2021 per region



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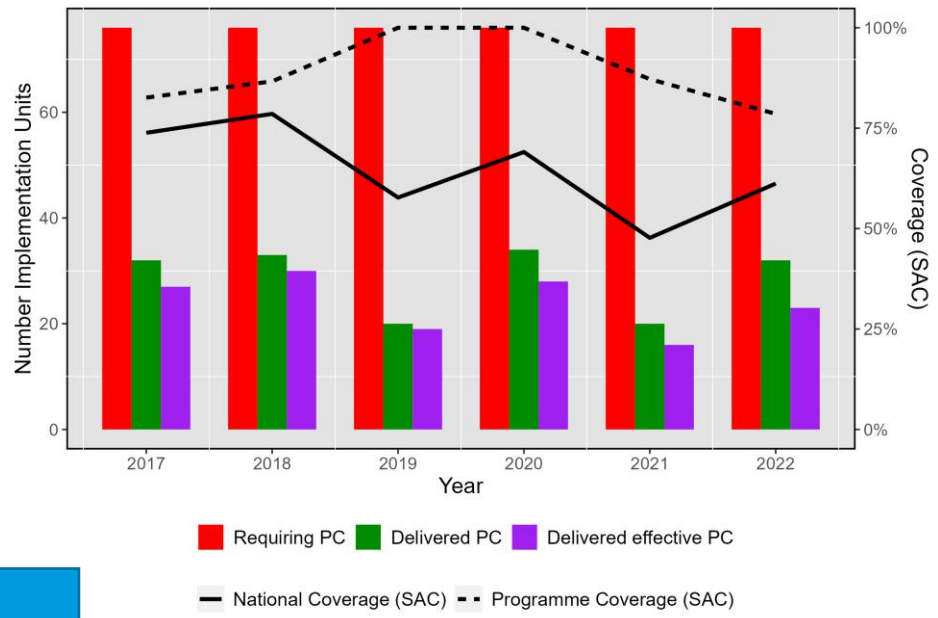
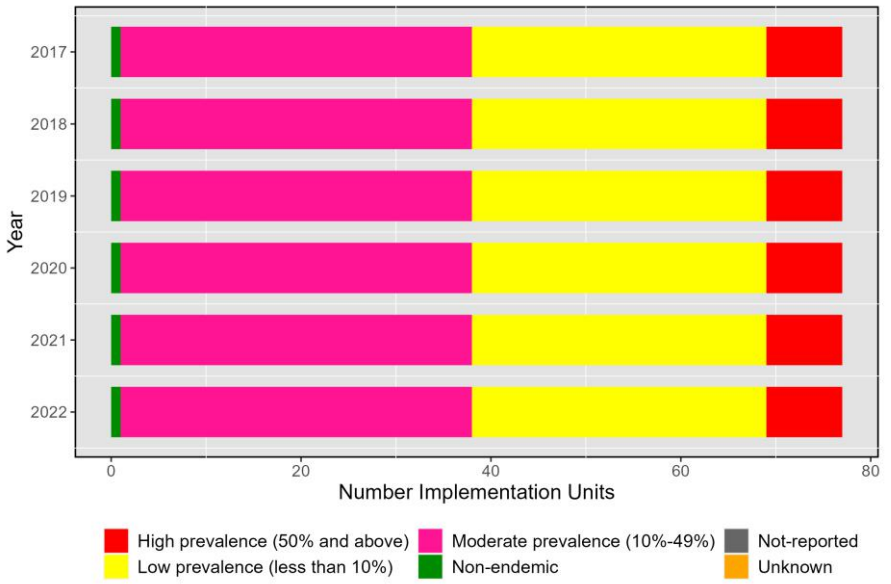
EXAMPLE 1



Indicator	2017	2018	2019	2020	2021	2022
Total population requiring PC	2430111	2272045	2362208	2300011	2641587	2735708
SAC population requiring PC	1482508	1343297	1394252	1367350	1584544	1629418
Total population targeted for PC	1325355	1217787	792042	916687	866701	1269372
SAC population targeted for PC	1325355	1217787	792042	916687	866701	1269372
Total population treated	1094757	1055253	804844	944298	755772	997263
SAC population treated	1094757	1055253	804844	944298	755772	997263
No. IU receiving PC	32	33	20	34	20	32
No. IU achieving effective coverage	27	30	19	28	16	23
Geographical coverage	42.10526	43.42105	26.31579	44.73684	26.31579	42.10526
Programme Coverage in total population	82.60104	86.65333	101.6163	103.012	87.20101	78.56349
Programme Coverage in SAC population	82.60104	86.65333	101.6163	103.012	87.20101	78.56349
National Coverage in total population	45.04966	46.44507	34.07169	41.05624	28.61053	36.45356
National Coverage in SAC population	73.84492	78.55697	57.72586	69.06045	47.6965	61.20363
No. IU delivering PZQ	11	16	14	11	16	13
No. IU delivering ALB/MEB+PZQ	21	17	6	23	4	19

BENIN
IA conducted

Endemicity	2017	2018	2019	2020	2021	2022
High prevalence (50% and above)	8	8	8	8	8	8
Moderate prevalence (10%-49%)	37	37	37	37	37	37
Low prevalence (less than 10%)	31	31	31	31	31	31
Unknown	0	0	0	0	0	0
Non-endemic	1	1	1	1	1	1
Not reported	0	0	0	0	0	0



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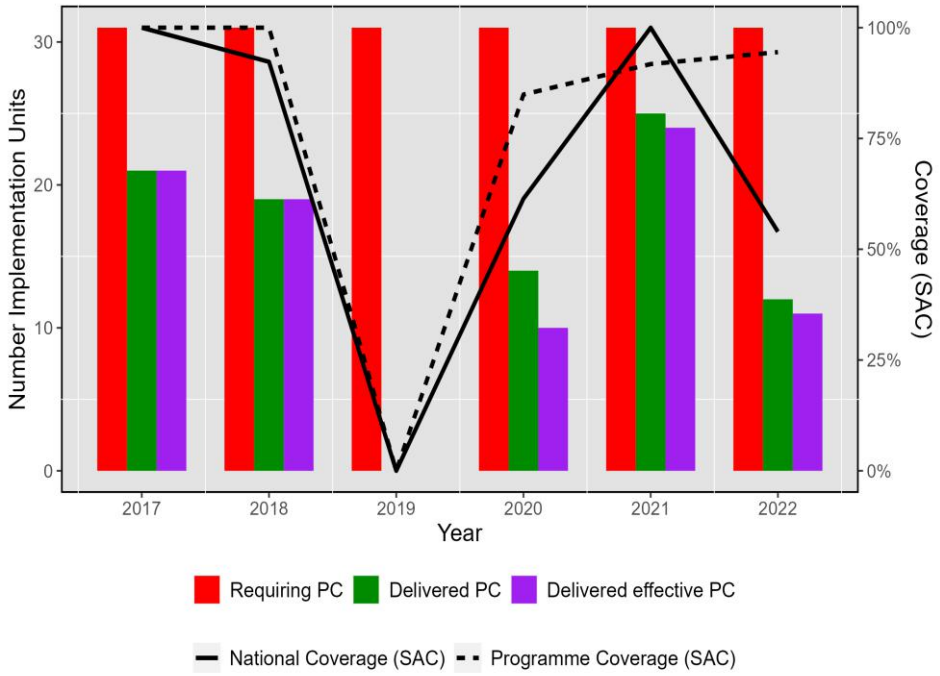
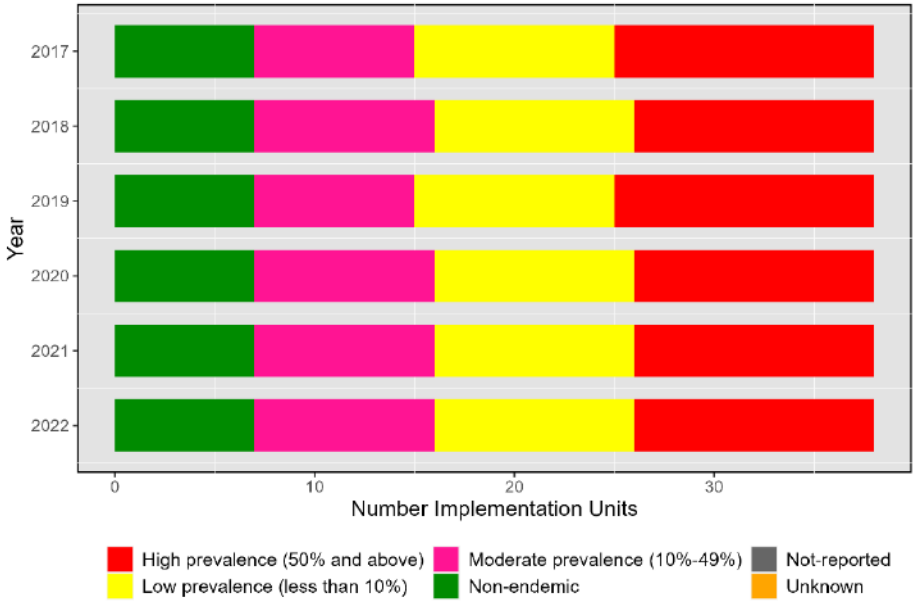
EXAMPLE 2



Indicator	2017	2018	2019	2020	2021	2022
Total population requiring PC	3927371	4031093	4340325	4435048	4557895	4522224
SAC population requiring PC	1577896	1763592	1922595	1864900	1916555	2015708
Total population targeted for PC	1636156	1896740	0	1348542	2388654	2296928
SAC population targeted for PC	1636156	1513411	0	1348542	2388654	1151245
Total population treated	1707875	1897591	0	1145079	2192543	1903537
SAC population treated	1707875	1627833	0	1145079	2192543	1087756
No. IU receiving PC	21	19	0	14	25	12
No. IU achieving effective coverage	21	19	0	10	24	11
Geographical coverage	67.74194	61.29032	0	45.16129	80.64516	38.70968
Programme Coverage in total population	104.3834	100.0449	0	84.91237	91.7899	82.87317
Programme Coverage in SAC population	104.3834	107.5605	0	84.91237	91.7899	94.48519
National Coverage in total population	43.48647	47.07385	0	25.81887	48.10429	42.09294
National Coverage in SAC population	108.2375	92.30215	0	61.40162	114.4002	53.96397
No. IU delivering PZQ	18	16	0	12	25	6
No. IU delivering ALB/MEB+PZQ	3	3	0	2	0	6

CONGO (no IA)

Endemicity	2017	2018	2019	2020	2021	2022
High prevalence (50% and above)	13	12	13	12	12	12
Moderate prevalence (10%-49%)	8	9	8	9	9	9
Low prevalence (less than 10%)	10	10	10	10	10	10
Unknown	0	0	0	0	0	0
Non-endemic	7	7	7	7	7	7
Not reported	0	0	0	0	0	0



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RPRG Discussion (5…i)

Effect of preventive chemotherapy with praziquantel on schistosomiasis among school-aged children in sub-Saharan Africa: a spatiotemporal modelling study

Christos Kokaliaris, Amadou Garba, Martin Matuska, Rachel N Bronzan, Daniel G Colley, Ameyo M Dorkenoo, Uwem F Ekpo, Fiona M Fleming, Michael D French, Achille Kabore, Jean B Mbonigaba, Nicholas Midzi, Pauline N M Mwinzi, Eliézer K N'Goran, Maria Rebollo Polo, Moussa Sacko, Louis-Albert Tchuem Tchuenté, Edridah M Tukahebwa, Pitchouna A Uvon, Guojing Yang, Lisa Wiesner, Yaobi Zhang, Jürg Utzinger, Penelope Vounatsou

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This online publication has been corrected. The corrected version first appeared at thelancet.com/infection on December 22, 2021

Department of Epidemiology and Public Health, Swiss Tropical and Public Health Institute, Basel, Switzerland (C Kokaliaris MSc, M Matuska MSc, G Yang PhD, L Wiesner MSc)

Summary

Background Over the past 20 years, schistosomiasis control has been scaled up. Preventive chemotherapy with praziquantel is the main intervention. We aimed to assess the effect of preventive chemotherapy on schistosomiasis prevalence in sub-Saharan Africa, comparing 2000–10 with 2011–14 and 2015–19.

Methods In this spatiotemporal modelling study, we analysed survey data from school-aged children (aged 5–14 years) in 44 countries across sub-Saharan Africa. The data were extracted from the Global Neglected Tropical Diseases database and augmented by 2018 and 2019 survey data obtained from disease control programmes. Bayesian geostatistical models were fitted to *Schistosoma haematobium* and *Schistosoma mansoni* survey data. The models included data on climatic predictors obtained from satellites and other open-source environmental databases and socioeconomic predictors obtained from various household surveys. Temporal changes in *Schistosoma* species prevalence were estimated by a categorical variable with values corresponding to the three time periods (2000–10, 2011–14, and 2015–19) during which preventive chemotherapy interventions were scaled up.

Findings We identified 781 references with relevant geolocated schistosomiasis survey data for 2000–19. There were

- A systematic review on the effect of preventive chemotherapy for schistosomiasis during the past 20 years has shown a reduction of 60% of the prevalence in SAC
- The same review has shown that the number of people requiring PC in the Africa region would be 111 M, if the treatment is targeted

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RPRG discussion (5…ii)

- Countries that have conducted MDAs and not adjusted treatment strategies based on new data
  - In alignment with the new SCH guidelines and the SCH M&E framework, adjust treatment strategies based on most recent surveys
- Countries that have conducted MDA after several rounds of MDA with >5 effective rounds and do not have IA data
  - Adjustment of treatment strategy by IU specific data.
  - Resource mobilization for IA
  - Conduct IA as soon as possible
  - Review treatment strategy based on new IA data

Thank you

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Challenges affecting progress: STH

Dr Pauline Mwinzi - ESPEN

Technical Officer SCH/STH

Dr Denise Mupfasoni – WHO/HQ

Medical Officer STH

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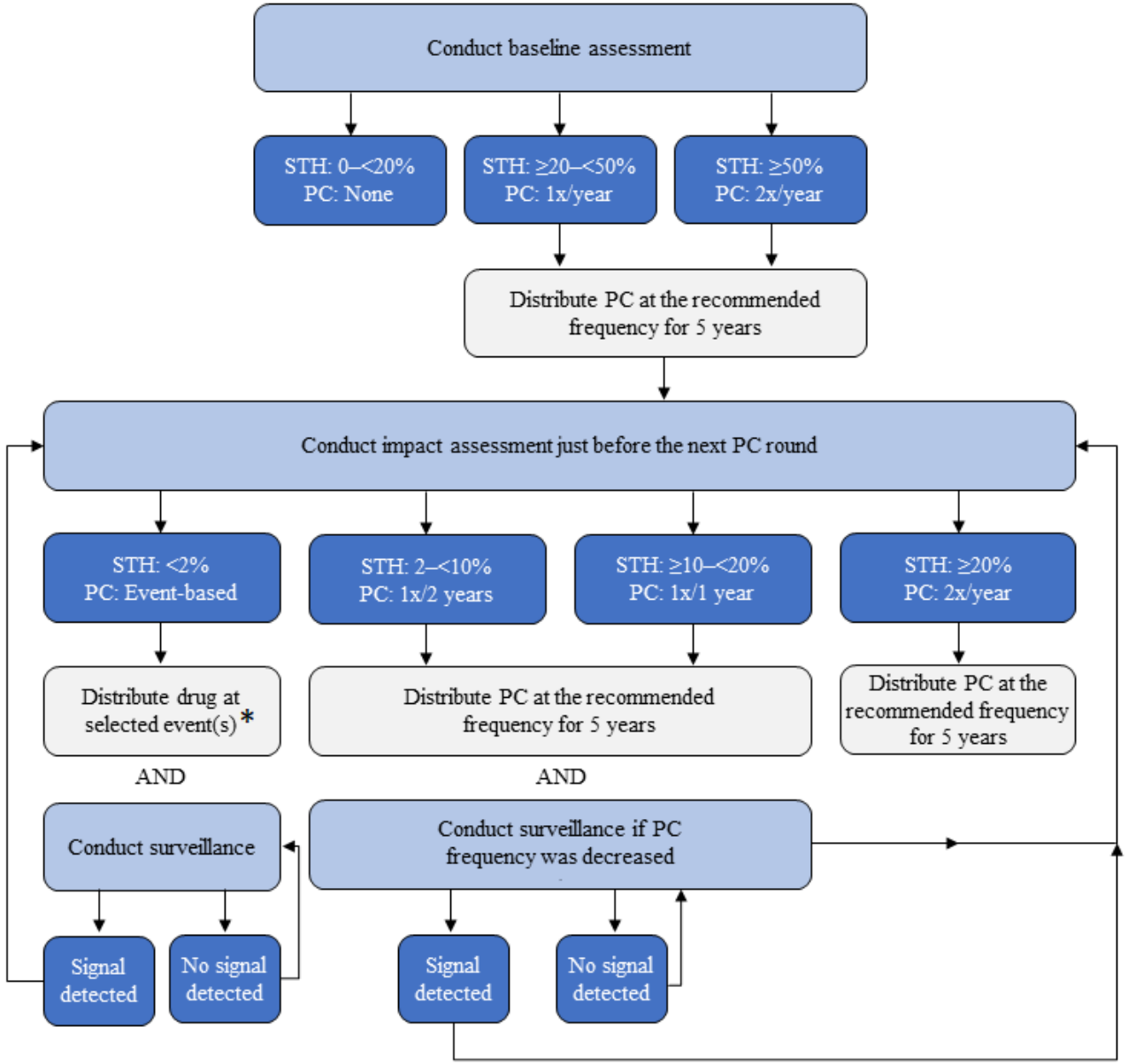
Challenges affecting progress: STH

- Countries not conducting Impact assessments after >5 Rounds of MDA
- Countries not adjusting treatment strategy following changes in endemicity after MDA

Decision tree for frequency of PC distribution for STH

*Note: The elimination of STH as a public health problem is defined as a prevalence of moderate-to-heavy intensity infection of <2% among children. While this is an important indicator to monitor the progress of STH control, it is **not** considered for the purpose of making decisions on the frequency of PC distribution.*



* PC targeting entire age groups may be suspended, but distribution may continue in appropriate settings (e.g., selected child-health visits, selected school years, or at antenatal care visits)

Challenges affecting progress: STH

- **Countries not conducting Impact assessments after >5 Rounds of MDA**
- **Countries not adjusting treatment strategy following changes in endemicity after MDA**

  - **Ethiopia**
  - **Malawi**
  - **Eswatini**

Countries not conducting Impact Assessments after >5 Rounds of MDA ….1

	MDA rounds as of 2022		Impact assessment			Comments
COUNTRY	ROUNDS	EFF	Done	Survey year	Needed	
Benin	17	8	Yes	2022	N	Adjust the frequency of treatment round
Burkina Faso	14	10	Yes	2017	N	Stop MDA
Burundi	16	14	Yes	2021	N	Need to send recent data to WHO
Cameroon	14	10	Yes	2018	N	Need to send recent data to WHO
Cabo Verde	6	4	Yes	2021	N	Adjust the frequency of treatment round
Central African Republic	6	0	N		N	
Côte d'Ivoire	11	5	Yes	2021	N	Need to send recent data to WHO
Democratic Republic of the Congo	6	0	N		N	
Ethiopia	15	0	Yes	2022	y	Partially
Gambia	7	1	N		N	
Ghana	16	6	Yes	2015	N	Need to send recent data to WHO
Guinea	14	4	N		N	
Guinea-Bissau	11	0	N		N	
Kenya	16	0	Yes	2017	N	Done but no sharing data
Liberia	9	5	N		N	
Madagascar	13	4	N		N	
Malawi	13	6	N		Y	

Countries not conducting Impact Assessments after >5 Rounds of MDA ….2

	MDA rounds as of 2022		Impact assessment			Comments
COUNTRY	ROUNDS	EFF	Done	Survey year	Needed	
Mali	15	9	Yes		N	Stop MDA
Mozambique	12	3	N		N	
Niger	13	3	Yes	2013	Y	Need to collect recent data
Nigeria	15	1	N		N	
Rwanda	11	11	Yes	2014	Y	Need to collect recent data
Senegal	17	4	Yes	2022	N	Adjust the frequency of treatment round
Sierra Leone	15	8	Yes	2022	N	Adjust the frequency of treatment round
Eswatini	7	5	N		Y	
Togo	17	5	Yes	2018	N	Need to send recent data to WHO
Uganda	16	5	N	2021	N	
United Republic of Tanzania	17	3	Yes	2022	N	partially
Zambia	11	2	N		N	
Zimbabwe	6	3	Yes		N	Need to adjust the PC

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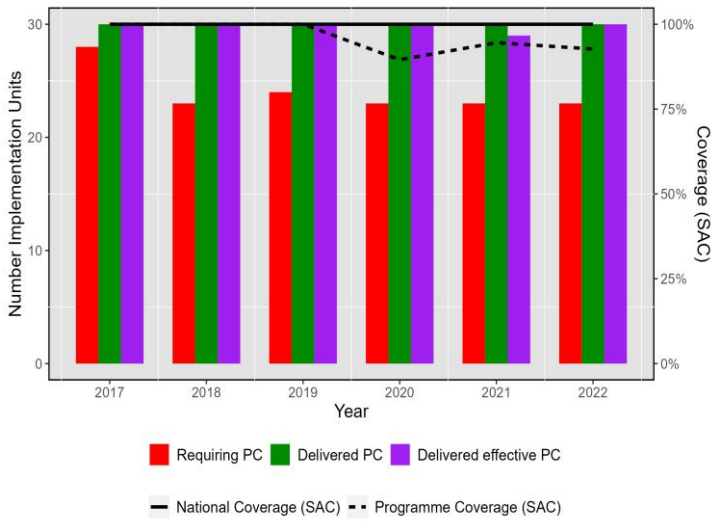
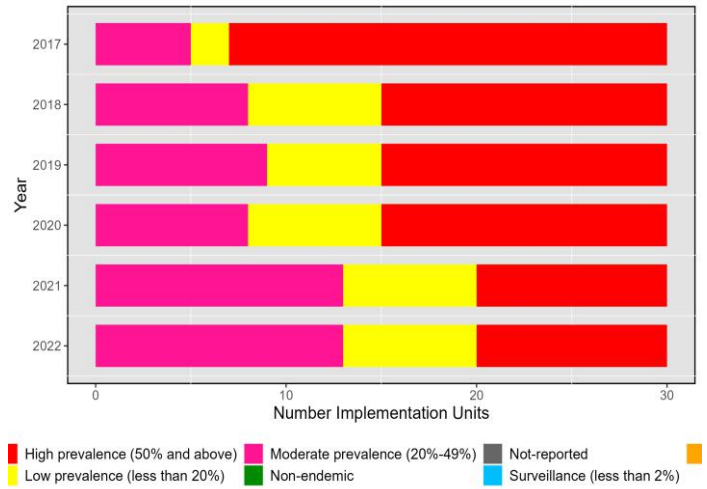
Country Example: Rwanda STH





	Year					
Endemicity	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
High prevalence (50% and above)	23	15	15	15	10	10
Moderate prevalence (20%-49%)	5	8	9	8	13	13
Low prevalence (less than 20%)	2	7	6	7	7	7
Surveillance (less than 2%)	0	0	0	0	0	0
Unknown	0	0	0	0	0	0
Non-endemic	0	0	0	0	0	0
Not reported[1]	0	0	0	0	0	0

[1] Data not submitted by country

	Year					
Indicators / Year	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Total population requiring PC	4,451,655	3,715,035	3,987,005	3,912,015	4,199,619	4,218,568
SAC population requiring PC	3,165,621	2,641,803	2,835,202	2,781,877	2,994,637	2,999,873
Total population targeted for PC	4,842,182	4,896,339	5,023,644	5,290,775	5,352,318	5,431,123
SAC population targeted for PC	3,443,329	3,481,840	3,572,368	3,762,330	3,766,967	3,862,135
Total population treated	5,177,888	5,139,219	5,278,879	5,139,847	5,079,060	5,091,389
SAC population treated	3,647,256	3,676,242	3,809,502	3,369,257	3,562,563	3,580,230
No. IU receiving PC	30	30	30	30	30	30
No. IU achieving effective coverage	30	30	30	30	29	30
Geographical coverage	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Programme Coverage in total population	106.9%	105.0%	105.1%	97.1%	94.9%	93.7%
Programme Coverage in SAC population	105.9%	105.6%	106.6%	89.6%	94.6%	92.7%
National Coverage in total population	116.3%	138.3%	132.4%	131.4%	120.9%	120.7%
National Coverage in SAC population	115.2%	139.2%	134.4%	121.1%	119.0%	119.3%
No. IU delivering ALB/MEB	30	30	30	30	30	30
No. IU delivering ALB/MEB+PZQ	0	0	0	0	0	0
No. IU delivering ALB+IVM	0	0	0	0	0	0
No. IU delivering ALB+DEC	0	0	0	0	0	0
No. IU delivering IDA	0	0	0	0	0	0

SAC: School-age children

PC: preventive chemotherapy

Geographical coverage: No. IU implementing MDA/No. IU requiring MDA

Programme Coverage: Population treated/Population targeted

National Coverage: Population treated/Population requiring treatment

NA: Data not available

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RPRG Discussion (1)

- **Countries not conducting Impact assessments after >5 Rounds of MDA**
- **Countries not adjusting treatment strategy following changes in endemicity after MDA**

  - **Countries needing to send recent data to WHO**

Challenges affecting progress: STH

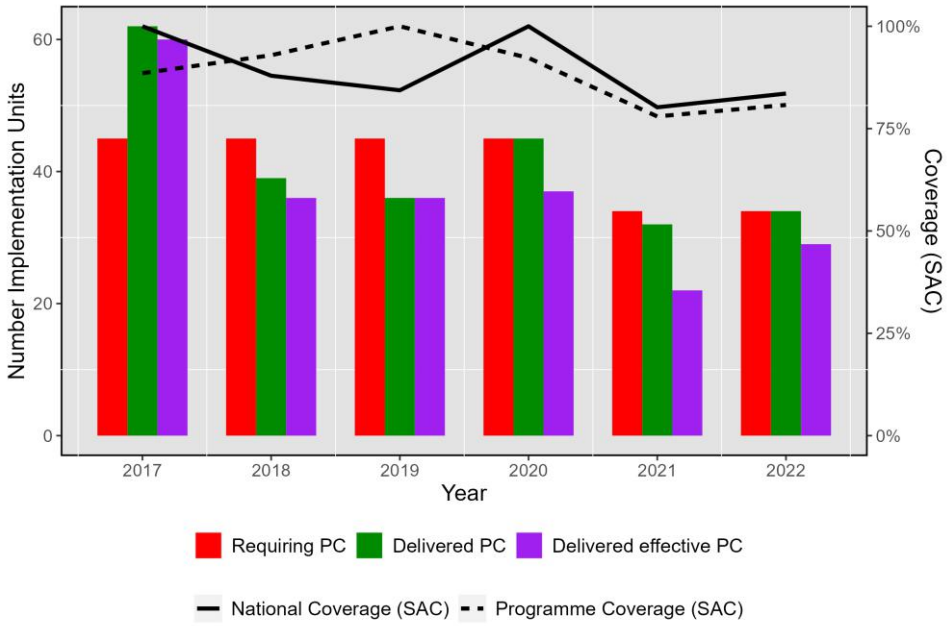
- Countries not conducting Impact assessments after >5 Rounds of MDA

- **Countries not adjusting treatment strategy following changes in endemicity after IA**

STH selected countries based on need to adjust treatment strategy following IA

Country	MDA rounds as of 2022	# of EFF	IA Done	Survey year	IA Needed	Comments
Benin	17	8	Yes	2022	N	Adjust the frequency of treatment round
Burundi	16	14	Yes	2021	N	Need to send recent data to WHO
Cameroon	14	10	Yes	2018	N	Need to send recent data to WHO
Côte d'Ivoire	11	5	Yes	2021	N	Need to send recent data to WHO
Ghana	16	6	Yes	2015	N	Need to send recent data to WHO
Rwanda	11	11	Yes	2014	Y	Need to collect recent data
Sierra Leone	15	8	Yes	2022	N	Adjust the frequency of treatment round
Togo	17	5	Yes	2018	N	Need to send recent data to WHO

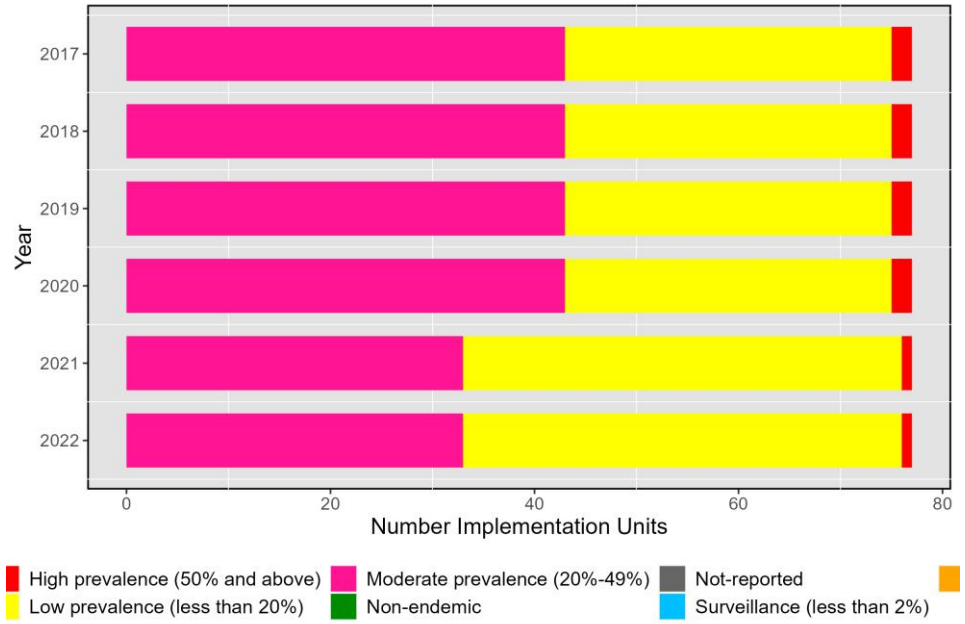
Country Example: Benin STH



Indicator	2017	2018	2019	2020	2021	2022
Total population requiring PC	2284230	2101153	2208676	2105464	1748668	1959363
SAC population requiring PC	1637723	1441209	1514931	1442832	1280474	1401080
Total population targeted for PC	2161773	1363564	1116406	1655971	1317036	1449299
SAC population targeted for PC	2161773	1363564	1116406	1655971	1317036	1449299
Total population treated	1914038	1267108	1278047	1527889	1027028	1170730
SAC population treated	1914038	1267108	1278047	1527889	1027028	1170730
No. IU receiving PC	62	39	36	45	32	34
No. IU achieving effective coverage	60	36	36	37	22	29
Geographical coverage	100	86.66667	80	100	94.11765	100
Programme Coverage in total population	88.54019	92.92618	114.4787	92.26544	77.98025	80.77905
Programme Coverage in SAC population	88.54019	92.92618	114.4787	92.26544	77.98025	80.77905
National Coverage in total population	83.79358	60.30537	57.86485	72.5678	58.73202	59.75054
National Coverage in SAC population	116.8719	87.9198	84.36338	105.8951	80.20686	83.55911
No. IU delivering ALB/MEB	16	7	26	18	28	15
No. IU delivering ALB/MEB+PZQ	21	17	6	23	4	19
No. IU delivering ALB+IVM	25	15	4	4	0	0
No. IU delivering ALB+DEC	0	0	0	0	0	0
No. IU delivering IDA	0	0	0	0	0	0

Issues:

- **New higher prevalence areas after IA**
- **Treatment adjustment following treatments**



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RPRG discussion (2):

- General guidance to countries not adjusting treatment strategy following changes in endemicity after MDA

- Review of finalized dossiers, RPRG members to discuss how the review will be conducted, and timelines.

Thank you

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Health Break (20 min)

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Discussion & RPRG recommendations