Annual Meeting of NTD National Programme Managers in the WHO African Region

Bonjour et bienvenue!

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Attendance: 17 April 2025

World Health Organization
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ESPEN EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

Kuwait Fund For Arab Economic Development

THE END FUND ENDING NEGLECTED DISEASES

Session 11: Strengthening NTD Elimination in the WHO African Region through Innovation, Integration, and Investment (Plenary)

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WHO/HQ Remarks

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GLIDE Remarks

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Global Schistosomiasis Alliance – Findings from INCORNTD

Anouk N. Gouvras

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Innovation, Integration and Investment

- Rapidly evolving global health funding landscape. Reduced resources for MDA, jeopardize progress made by countries, risk to donation programme.
- International Conference on NTD Research in Africa (InCORNTD):
  - Technical Symposium on Health System Integration for Schistosomiasis and NTDs
  - Break Out Session and Rethinking MDA campaigns: Leveraging integrated health campaigns for improved effectiveness and impact
  - Report available: https://bit.ly/GSA-InCORNTD-25

Innovation, Integration and Investment

- Cost-benefit and cost-effectiveness analysis models to test different integration options, helping decision makers identify what would work best in a particular context.
- Community and workforce engagement and co-design strategies that build trust and acceptability.
- Harness research pilots to:
  - Capture data that fits locally relevant contexts,
  - Trial innovative approaches (e.g. leverage One Health, new technologies),
  - Build buy-in and adapt/transform where needed.

Innovation, Integration and Investment

- Create a culture for change – Governments working across departments and sectors should use available tools to :
  - Conduct a situation analysis of existing policies and national plans – are there integration opportunities? When are they schedule for review?
  - Map existing campaigns and platforms, including stakeholders and funding sources. Do target populations align?
  - Assess needed technical expertise, are there gaps?
  - Map product supply chains and logistics, can they align?
  - Assess readiness of existing data systems, do they allow for interoperability?
- Develop coordination and integration strategies that reflect the governance structures of the health system (whether central or devolved).

Agenda

- **Madagascar** - Dr. Nely Alphonse Jose/Dr Patricia Rasoamihanta-Martin
- **Rwanda** - Mr. Ladislas Nshimiyimana
- **Senegal** - Dr. Ndéye M'backé Kane
- **Ethiopia** - Mr Tesfahun Bishaw
- **Linksbridge** - Zaiyanatu Abubakar Umar, Aline Benson
- **Q&A** with panel of speakers

Implementation of Mass Drug Administration for Lymphatic Filariasis - the progress and the effectiveness and financial savings of integrating into an existing Polio campaign

Dr Patricia Rasoamihanta, Dr Vatsiharizandry Mandrosovololona, Dr Kpandja Djawe, Dr Denise Mupfasoni, Dr Didier Bakajika, Joses Muthuri Kirigia and Prof. Laurent Musango

Presented by : **Dr Patricia MARTIN RASOAMIHANTA**

NTDs Focal point, **WCO, Madagascar**

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I. INTRODUCTION

- Island, with an area of 587,041 km^2
- Pop: 30,626,890 million
- Number of IUs (districts) : 114

Neglected Tropical Diseases 1.5 billion cases, 39% of the global burden,

Madagascar:

LF in 87/114 districts (4 stopped MDA, MDA in 83)

- ❑ exposure: 69.6% pop
- ❑ Progress (2018-2023): endemic health districts decreased from 84.2% to 76.3% of which 4 are under surveillance and no longer require treatment
- ❑ **Objectives on Mass Drug Administration (MDA):**

  Therapeutic Coverage national Rate **>65%** in districts

LF endemicity

- ❑ **Coendemicity:**
- SCH in 89 DS
- STH in 89 DS
- Taeniasis in 31DS

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I. INTRODUCTION 2/2

Catalyst for Integrating

- **Government endorsement of Policy and Global Health priorities**:
  - Government is already committed to promoting the integration of activities and care through mobile clinics to improve access to primary healthcare for its population.
- **Resource Optimization**:
  - Technical and financial partners also adhere to the global integration initiatives for the rational management of resources.
- **Cost-effectiveness**:
  - The pooling of efforts, in particular the selection and use of a single service provider to replicate the tools for the two programmes
- **Community Engagement/Advocacy/Communication**:
  - Integrated activities conducted at all levels (national, regional, district and local): social mobilization and communication plan, community meetings, advocacy meetings etc

II. METHODS (1/2)

- **Study Area and Population**
  - The 83 districts where LF is endemic
  - 21,336,057 people living in these 83 districts

- **Study Design**
  - **observational** cross-sectional study
  - Its primary goal was to :
    - ✓ provide a snapshot of the implementation of integrated LF MDA in target districts and
    - ✓ to evaluate its effect on **therapeutic coverage and financial efficiency**

- **Medication Strategy and distribution Strategies (MDA)**
  - Mass **treatment once a year** per district
  - Target population: **>2 years old**
  - Regimen: dual-therapy (**DA:** Diethylcarbamazine + Albendazole)

    triple-therapy (**IDA:** Ivermectine +Diethylcarbamazine + Albendazole
  - **2,111 Basic Health Centres** (BHC) involved
  - 15,055 villages involved.
  - **30,110 Community Distributors** were mobilized and charged with responsibility for distributing medicines among the 83 districts

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II. METHODS (2/2)

Estimating Financial Savings of Integrating LF MDA into Polio Immunization Campaigns

The study focused on the expenses associated with :

1- coordination (supervision),
2- logistics,
3- travel and allowances,
4- communication,
5- training of trainers,
training of BHC
and training of CHW .

For each of these cost items, the financial savings per item : $[\![FS]\!]\_i$

Difference between potential expenditure without integration : $[\![EXP]\!]\_without$

Actual expenditure with integration : $[\![EXP]\!]\_with$.

In algebraic : $[\![FS]\!]\_i = [\![EXP]\!]\_Without - [\![EXP]\!]\_With$

The total financial cost savings due to the integration of LF MDA into the polio immunization campaign's ($\mathbf{TFS_{MADAGASCAR}}$)

equals the sum of financial expenditure savings across the seven cost items ($\sum_{i=1}^{i=7} \mathbf{FS_i}$)

In algebraic : $\mathbf{TFS_{MADAGASCAR}} = \sum_{i=1}^{i=7} \mathbf{FS_{i=1,\dots,7}}$

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III. RESULTS (1/3)

Administrative coverage

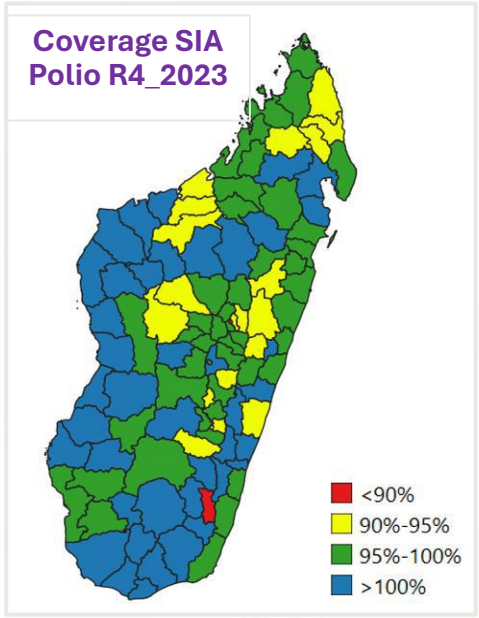
In 2023

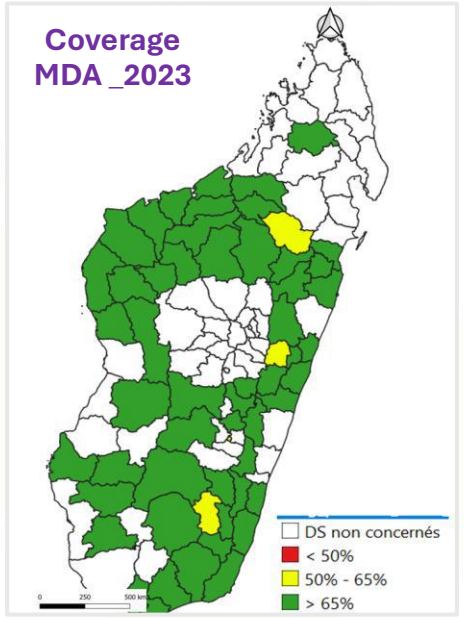
- Only 2 (3%) districts with integration have an administrative coverage between 90-95% for polio
- 3 (5%) districts with integration have an administrative coverage between 50-65% for MDA

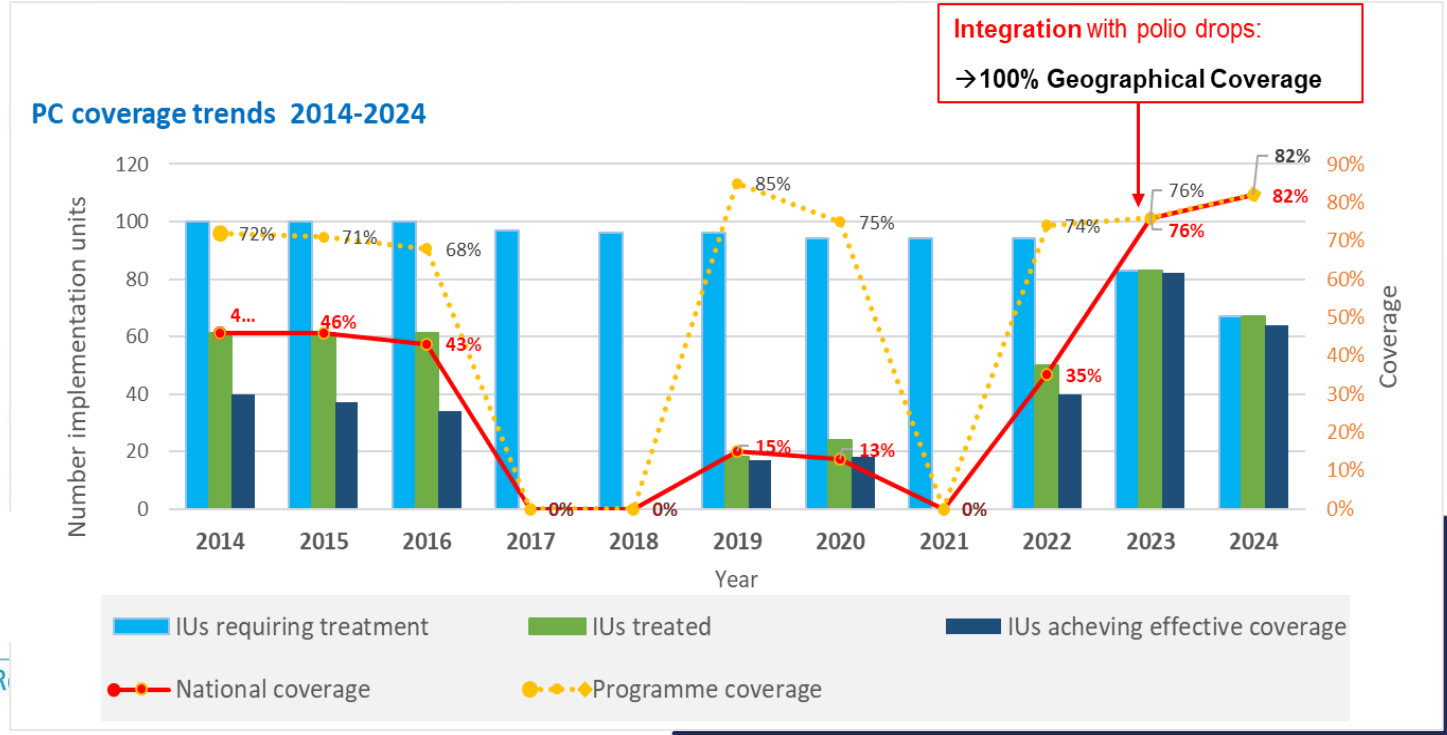
In 2024

- all districts have reached the target either for polio (95%) or MDA (65%)

Cases of **LF-related morbidity** reported (**MMDP):**
→ 14,069 hydrocele ; 15,303 lymphoedema







III. RESULTS (2/3)

Financial savings from integrating MDA into the polio vaccination campaign

Tab1 : Breakdown of total expenditure with and without integration, and financial savings

→ **2023**

$ 1,058,170
financial savings

ACTIVITIES (2023)	(A). Budget without Integration (US$)	(B). Exact Expenses with integration (US$)	(C). Financial Gain (US$) (C=B-A)
Coordination – supervision-Distribution	709,120	238,272	560,848
Logistics	53,135	9,698	43,437
Communication	117,685	-	117,685
Trainings	518,957	92,757	426,199
Total	**1,398,897**	**340,727**	**1,058,170**

→ **2024**

$ 172,046
Financial savings

ACTIVITIES (2024)	(A). Budget without Integration (US$)	(B). Exact Expenses with integration (US$)	(C). Financial Gain (US$) (C=B-A)
Coordination – supervision-Distribution	140,159	21,436	118,723
Logistics	7,548	361	7,186
Communication	14,166	-	14,166
Trainings	40,293	8,322	31,971
Total	**202,166**	**30,120**	**172,046**

In two years, $ 1,230,216 savings thanks to the integration of MDA and AVS Polio

III. RESULTS (2/3)

Discussion/key findings

- The integration achieved extensive geographic coverage, reaching 15,052 out of 15,055 villages in the target 83 districts (coverage of 99.98%).

- Overall therapeutic coverage of 75.60% was achieved, with 16,130,212 people receiving either DA or IDA therapy out of a target population of 21,336,057 people.

- 14,069 hydrocele ; 15 303 lymphoedema cases detected thanks to the mobilization of volunteers

- By **sharing activities** such as coordination, supervision, logistics, travel allowances, training and communication materials between the LF MDA and polio campaigns, the estimated financial saving was **$1,230,216**

→ Utilization of a single headquarters for monitoring and evaluation of activities and reporting, and the same supervision teams at the regional health offices and districts, as well as integrated training for both polio campaign vaccinators and drug distributors for NTD, boosted effectiveness and financial efficiency.

→ In terms of logistics, the supply was unique, and the same vehicles transported vaccines and LF drugs, time markers, and other management tools required for both campaigns. This helped to reduce transport costs enormously.

→ Communication was effective through launches by the authorities' carrying messages about both campaigns. Social mobilization was effective with the involvement of local authorities (village chiefs), religious leaders, school directors, and traditional practitioners who were all involved in raising awareness among the population.

IV-CONCLUSIONS

LF MDA integrated into polio immunization campaign:

- ✓ Efficiency +++
- ✓ Achievement of objectives set by both programs
- ✓ Importance of collaboration between health programs
- ✓ Promoting innovation and research in the planning, implementation and monitoring/evaluation of health programs for greater effectiveness and efficiency
- ✓ Replication of the model in other endemic countries

→ **A good example of how we can reach our goal of eliminating NTDs by 2030**

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Rwanda: Coordinating partners and stakeholders for health intervention delivery through a single platform

Ladislas NSHIMIYIMANA
Director of NTD & Other Parasitic Diseases Unit
Rwanda Biomedical Centre
Ministry of Health

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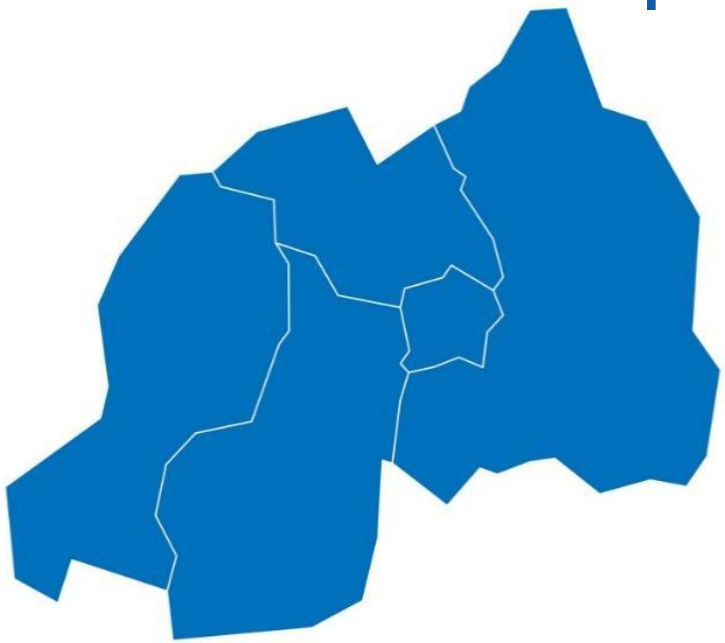
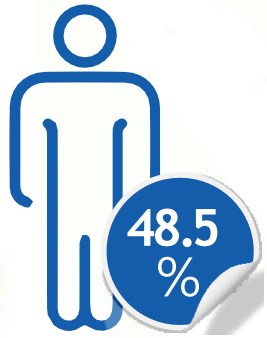
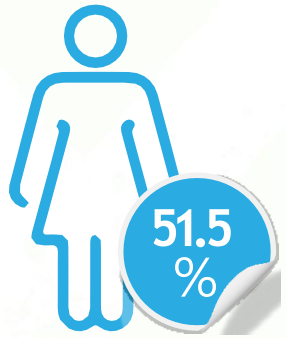
Country Profile

Population: 13,246,394







60,000 CHWs

Source: 5th Rwanda Population and Housing Census, 2022

4.0 Average Household Size

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Rwanda NTDs Country Profile

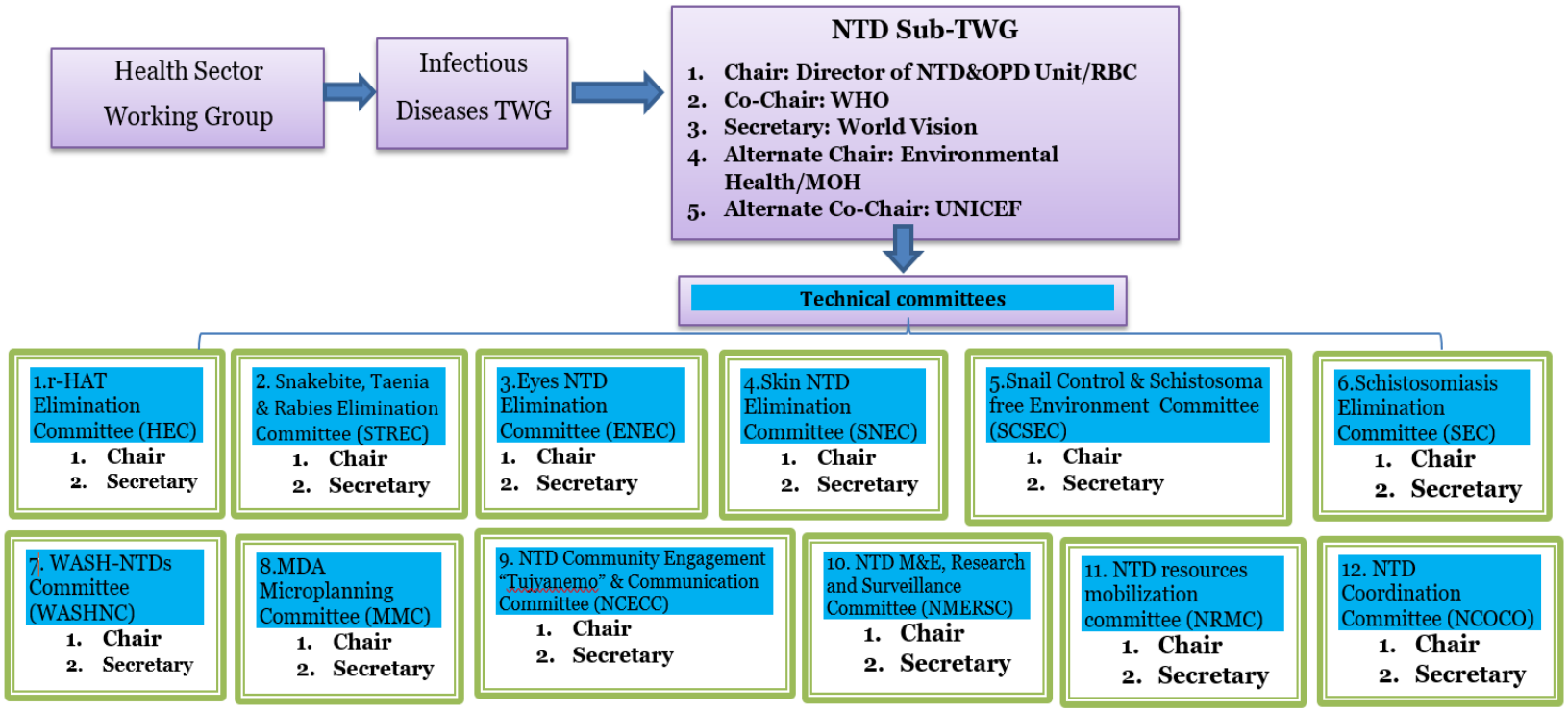
NTD	Current status
Soil Transmitted Helminthiasis	- 38.7% overall prevalence(2020 impact assessment) - 46.1% among adults - 38.8% among children aged 5-15 years - 30.2%) among children of 1-4 years
Schistosomiasis	Endemic in 1,013 administrative cells across 30 districts
Taenia/ Cysticercosis	- Around 10,000 cases of Taeniasis reported annually - Scarce evidence of cysticercosis in Humans
Scabies	Sporadic cases reported as outbreak
Podoconiosis	Estimated 6,000 cases countrywide
Leprosy	An average of 30 annual new cases are
Tungiasis/ Jigger Disease	Around 1,000 cases annually
Snake bite envenoming	Around 1,000 cases annually
9. Rabies (dog bites)	Around 500 dog bites annually

NTD	Current status
Historically endemic: **Yaws, Trachoma, Lymphatic Filariasis, Onchocerciasis**	- Historically endemic - Onchocerciasis: on **going Elimination Mapping** **- LF:** surveillance under Podo treatment centers
Rhodesiense Human Africa Trypanosomiasis & Dracunculiasis/ Guinea Worm	- EPHP of r-HAT validated 2022 - Dracunculiasis validated as absent from Rwanda in 2004
Mycetoma, Chromoblastomycosis and other deep mycoses	Limited evidence (planned integrated screening of skin NTDs)
1) Buruli Ulcer 2) Chikungunya 3) Dengue 4) Echinococcosis 5) Foodborne trematodiases 6)	Never been confirmed or reported in Rwanda, desk review ongoing

Multisectoral NTD-WASH Technical Working Group

"Intensifying cross-cutting approaches"

Annex I: Organization chart of NTD Sub-Technical Working Group (TWG)



12 NTDs working committees

- Cluster Ministries and Adjacent Institutions (WASH, NTDs, One Health)
- NTD & WASH domestic partners
- Academia
- Local Government
- Religious leaders
- Security Organs (RNP)
- UN Organizations

➢ Joint planning in the TWG
➢ Consideration in specific plan (ministries, organization)

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Integrated Maternal and Child Health Week (MCH) Campaign

- WASH and MDA for STH/SCH
- 8 Contacts (ANC)
- Delivery at Health Facility
- Family Planning
- Exclusive Breast Feeding for 6 Months
- Full Vaccination
- Prevent Malaria
- Malnutrition Screening

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Integrated MCH Week Campaign
Coordination Mechanism

Republika y'u Rwanda

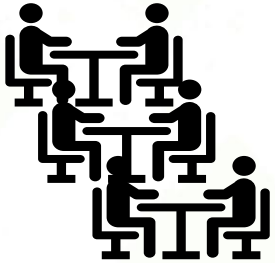
Hehe n'igwingira

Icyumweru cyahariwe kwita ku buzima bw'umubyeyi n'umwana

Hehe n'igwingira: Twite ku buzima bw'umubyeyi n'umwana

World Health Organization · THE WORLD BANK · USAID FROM THE AMERICAN PEOPLE · unicef · UNFPA

rbc Rwanda Biomedical Centre · NCDA · imbuto foundation · CRS · Enabel · jhpiego · Gavi The Vaccine Alliance · World Vision



Prepare, Fund, and Implement the MCH Week

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MCH Week Campaign

Implementation Arrangement

Community-School-Health Facilities

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Lessons Learned

- Effective planning, implementation and M&E;
- Efficiency use of resources (financial, human resources, time);
- Domestic resources mobilization;
- Sustainability of MDA intervention;
- Shared achievement of partners and stakeholders' goal

Launch of the Integrated MCH Week January 2025

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MINISTÈRE DE LA SANTÉ ET DE L'ACTION SOCIALE

Planification de l'intégration de la CPS, de la schistosomiase et des STH au Sénégal

DE LA RECHERCHE A LA PRATIQUE

Dr Ndeye Mbacké KANE,
Coordonnateur Programmme MTN Sénégal

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PLAN

01 Contexte et justification

02 Résultats de la recherche intégration campagnes RCPS et STH

03 Processus de planification de l'intégration campagnes CPS et STH

02 Défis et Opportunités

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Contexte et justification

Sénégal à l'instar des autres pays de la région africaine est Co endémique au paludisme et les Schistosomiases et STH
Objectifs communs de leur contrôle et élimination en 2030 (ODD 3)

Approche intégrée des activités MTN devrait permettre de déboucher sur de meilleurs résultats en matière de santé, un meilleur rapport coût/efficacité et une meilleure gestion des programmes

Intégration: pris en compte dans le pilier 2 du plan stratégique de lutte contre les MTN au Sénégal

Permet d'améliorer l'efficacité et l'efficience dans la mise en œuvre des interventions de lutte contre les MTN grâce à une intégration des activités, et de partager les pratiques prometteuses en matière de mise en œuvre collaborative

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Etude sur l'approche intégrée campagnes CPS et antihelminthiques menée au Sénégal

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Objectifs de l’étude

Objectif 1

Évaluer l'innocuité et tolérance de l’administration conjointe de médicaments de la CPS et des anti-helminthiques chez les enfants d'âge préscolaire et scolaire au Sénégal.

Objectifs 2

Évaluer effets des traitements combinés CPS et anti helminthiques sur la prévalence du paludisme, de l'anémie et des infections aux helminthes chez les enfants d’EAPS et AES au Sénégal

Malaria Journal

RESEARCH Open Access

Feasibility and safety of integrating mass drug administration for helminth control with seasonal malaria chemoprevention among Senegalese children: a randomized controlled, observer-blind trial

Objectif 3

Explorer les perceptions des parents ou gardien(ne)s des enfants de l'étude, des prestataires de CPS/MTN et des responsables de programme concernant l'acceptabilité, la faisabilité, les obstacles, les facilitateurs et les aspects pratiques de l'utilisation de l'approche intégrée CPS anti helminthiques.

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Méthodologie

Réunion de discussions et partage du protocole en 2021

Etude MALHELMIN 2

Etude quantitative

- Groupe 1 : Vit A + Zinc le jour 0, suivi d'un passage CPS les jours 1, 2 et 3 = 200 enfants.
- Groupe 2 : PZQ + Vit A au jour 0, suivi d'un passage CPS aux jours 1, 2 et 3 = 200 enfants
- Groupe 3 : ALB + PZQ le jour 0, suivi d'un passage CPS les jours 1, 2 et 3 = 200 enfants.

Etude qualitative

- Entretiens structurés chez les parents/gardien(ne)s, Agents d'exécution de la CPS et NTD portant sur l'acceptabilité, la faisabilité, les facilitateurs, les facteurs favorables et les obstacles à l'administration conjointe de médicaments de la CPS, de l'ALB et du PZQ

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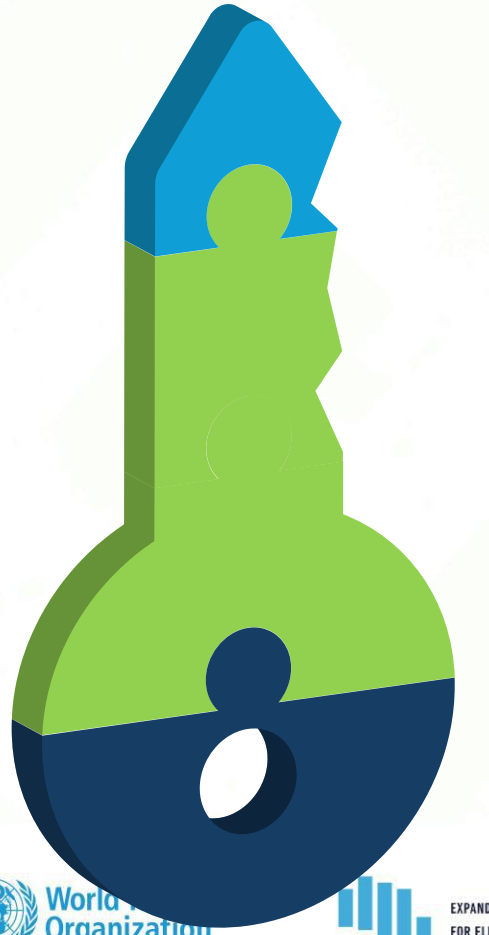
Résultats

Faisabilité, acceptabilité et la tolérance de cette approche intégrative SMC + PZQ ou SMC + PZQ + ALB.

Efficacité avec un coût amoindri
Économie de ressources grâce à une synergie d'actions des programmes de lutte (PNLP, PNL MTN)



Impact sur la morbidité
Les enfants (SMC+PZQ) avait un risque moins élevé d'avoir une anémie sévère

Prévalence du paludisme moins élevé que dans les Bras 2 et 3 (post administration)

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Processus de planification de l'intégration campagnes CPS et SCH

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Le Sénégal prévoit de mettre en œuvre un projet pour le traitement prise de la schistosomiase chez les moins de 05ans pour une durée de 05 ans en 2 phases :

Une phase pilote : 5DS ciblés sur 2 ans

02 districts de la région de Saint louis (Richard Toll et Dagana) et Trois autres districts de la région de Kédougou (Salémata , Kédougou et Saraya)

Une seconde phase de mise à l'échelle dans les autres DS du bassin du fleuve /appui des partenaires

Réunion de planification de l'intégration des campagnes CPS et SCH

- **Objectif** : Rassembler et mobiliser les acteurs clés pour soutenir afin de faciliter l'introduction et l'intégration
- Présence toutes les parties prenantes
- Identification: stratégies, défis et solutions
- Elaboration plan d'action sur les thèmes suivants :
  - Protocole, stratégies d'intégration ou d'introduction couverture faisabilité
  - Quantification, logistique , pharmacovigilance, réglementation
  - Communication, formation, coordination
- **Stratégie intégration:**
- MDA SCH et CPS
- Routinisation avec la PECADOM

Groupe 1

Groupe 2

Groupe 3

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Etapes

Rencontres de discussions et de partage des résultats de l'étude au DS Saraya avec PNLP et les DRS **01**

Atelier de **planification** **02**

Elaboration d'un plan de mise en oeuvre . **03**

Réunion en ligne de discussions sur les aspects pratiques de microplanification conjointe avec le PNLP, l'OMS TDR,,universitaires **04**

Elaboration d'un protocole sur l'étude de la faisabilité de l'administration intégrée PZQ pédiatrique à 2 modèles de distribution d'antipaludiques **05**

Défis et opportunités

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Défis et opportunités

Défis

- Coordination et suivi conjoints avec les autres programmes et directions du MSAS (DSME, ARP, SEN PNA, Cellule de soins de santé primaires, SNEISS,
- Acceptabilité : crainte des effets secondaires ou méconnaissance des bénéfices du traitement
- Disponibilité permanente du praziquantel pédiatrique dans le pays
- Intégration des outils de gestion et de communication
- Durabilité → routinisation
- Financement

Opportunités

- PNLMTN et PNLP dans une meme direction du ministère
- Intégration des revues des données PNLP,PNLMTN
- Utilisation meme plateforme DHIS2 et digitalization des données (CPS et MDA SCH/STH
- Existence d'une agence de régulation (ARP): AMM, et pharmacovigilance
- Existence d'une SEN PNA avec un système d'approvisionnement et de distribution bien huilé
- Utilisation même plateformes communautaires/scolaire

Prochaines étapes

- **Soumission protocole étude recherche mise en oeuvre au comité d'éthique**
- **Acquisition du praziquantel pédiatrique**
- **Micrplanification conjointe**
- **Révision des outils des formulaires DHIS2 et supports de communication**
- **Formation des acteurs**
- **Mise en oeuvre phase pilote**
- **Evaluation**

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Field experience on programmatic integration for the eradication of dracunculiasis, Ethiopia

Tesfahun Bishaw, Dr. Zeyede Kebede

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Background

- Population size: ~112.1 million
- Refugee Population size: ~ 434,922
- Twelve Regions plus two City Administrations
- 1,223 Woredas
  - 2 endemic
  - 15 high risk
- 21,809 health facilities

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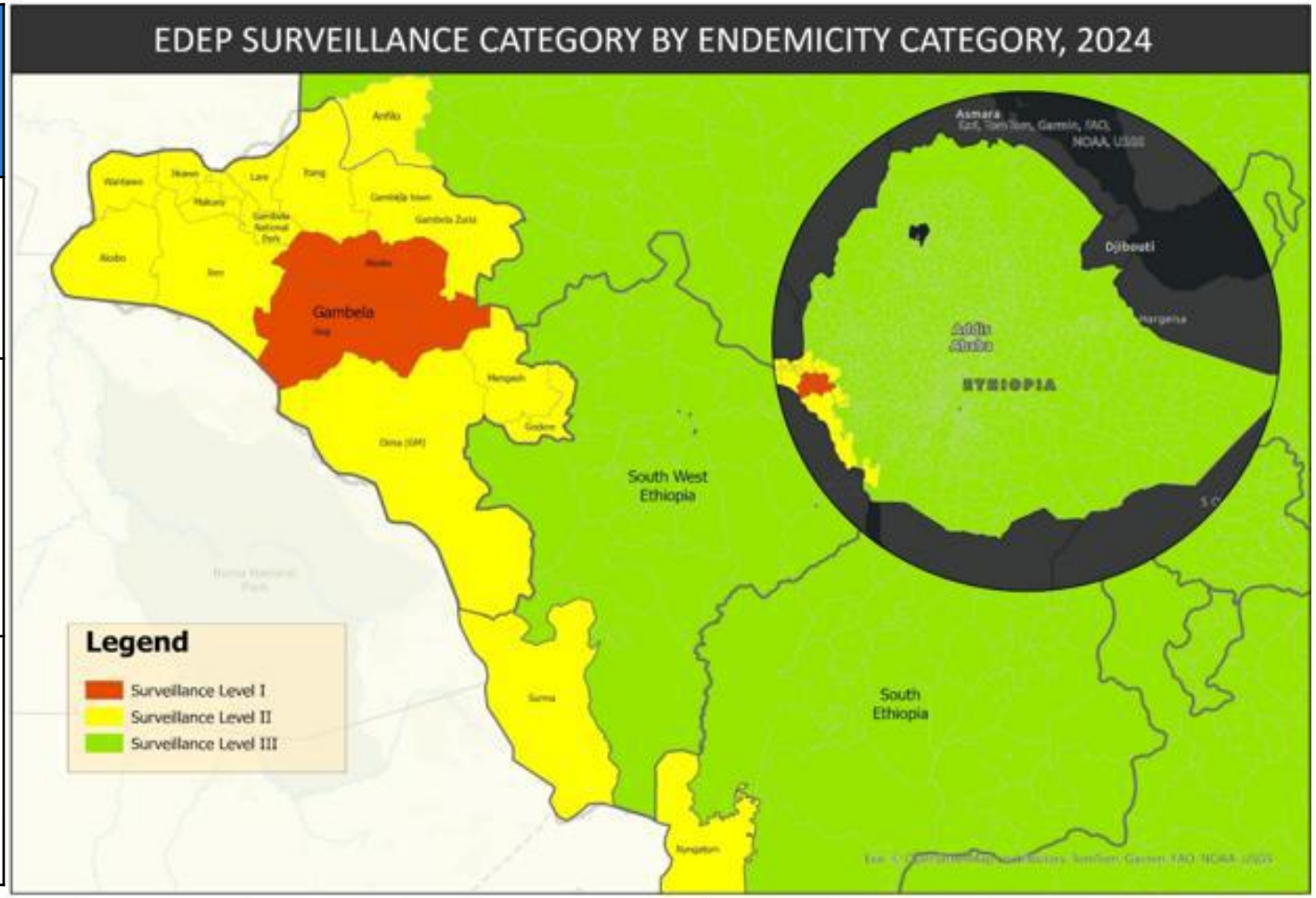
EDEP-Surveillance Category by Endemicity Status, 2024

Category	# of Woredas	# of VAS/ NVAs
Endemic, (level I)	2	198/190
Formerly Endemic, (level II)	15	944/86
Never Endemic, (Level III)	1,206	NA



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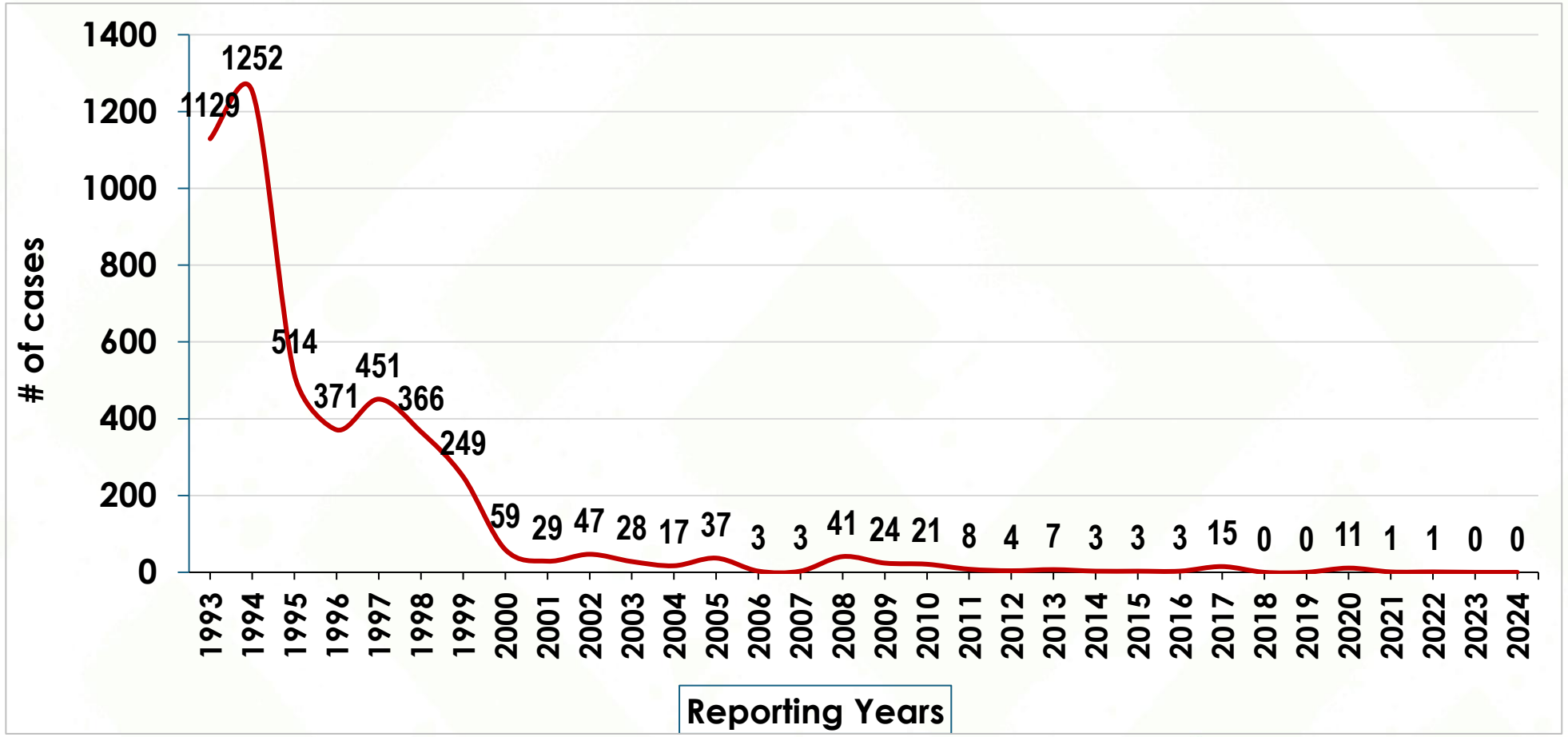
Epidemiological Situation

Human cases by year: 1993-2024 (N=4,697)



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Epidemiological Situation ....

Animal infection by species

64

23

14

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Program interventions

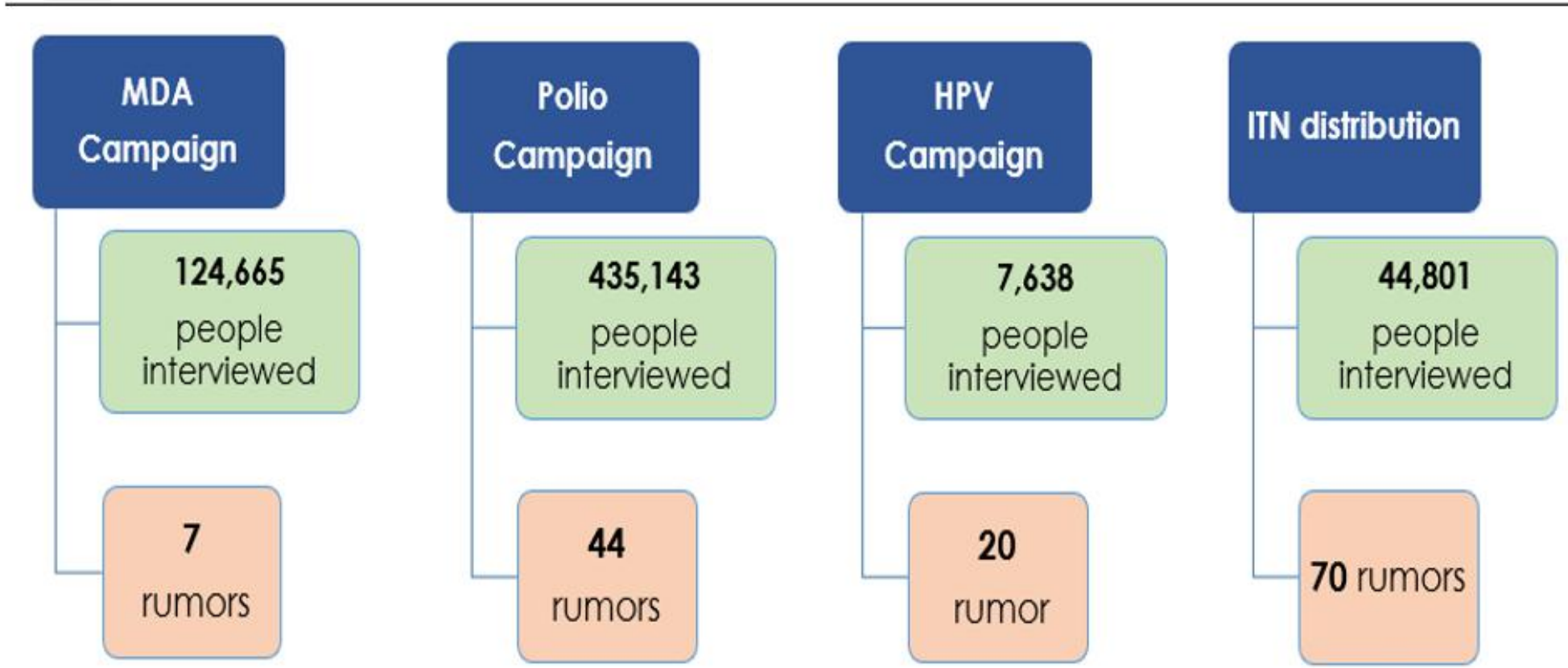
- Community-based active surveillance in endemic and high-risk village including refugee and cross border surveillance
- Case management and containment
- Provision of safe drinking water supply for endemic villages
- Health education and communication
- Distribution of cloth and pipe filters
- Treatment of ponds with abate chemical
- Environmental management (filling and drainage of ponds)
- Proactive tethering of domestic animals

Integration

One of the strategic shifts in approaches to addressing NTDs in the global NTD road map is the programmatic approach: Moving from vertical disease program to cross cutting approach

- Intensify cross-cutting approaches by
  - ✓ Integrating interventions for several NTDs (joint delivery of interventions that are common to several diseases)
  - ✓ Mainstreaming them into national health systems,
  - ✓ Coordinated with related programs (e.g. WASH, vector control, other disease programs)

Integration of GW case search with public health campaign in endemic and high-risk districts in 2024



In total, 612,247 people were interviewed for case search and 141 GW rumors were reported and investigated withing 24 hours

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Integrated training for GWD active case search and polio (AFP) surveillance

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Other opportunities used for GWD Case Search

- Trachoma MDA
- Onchocerciasis MDA
- Lymphatic Filariasis MDA
- Ration distribution in refugee camps
- Deworming campaigns
- Nutrition surveys in refugee camps

Integration of GWD surveillance in Emergency preparedness and response

- GWD Surveillance were also integrated into emergency response activities
  - Measles vaccination campaigns
  - Polio vaccination
  - AFP surveillance
  - COVID-19 vaccination
  - Epidemic-prone disease screening at cross-border entry points surveillance
  - Emergency preparedness and response trainings

Integration opportunity
Collaborative Action Strategy for Health Campaign Effectiveness

- MOH endorsed CAS
- Feasibility assessment conducted and the result disseminated at national and global
- Stakeholders Identified (donors, IP, and government sectors)
- CAS socialization conducted
- National Steering Committee formed, and strategic guidance will continue
- TWG -3 groups (Plan and Impel, MERLA & Finance –policy formed and produce national CAS strategy
- Global recommendation customized to national context
- Campaigns calendar mapped (2025-2026)-nationally
- National CAS strategy developed
- CAS Implementation plan developed and costed
- Regional CAS rollout and implementation guidelines ongoing
- Preparation completed for Measle with Nutrition upcoming May 2025 campaign

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Using the Campaign Hub to Identify Opportunities for Co-delivery

Zaiyanatu Abubakar Umar – Nigeria Federal Ministry of Health

Aline Benson – Linksbridge

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Health Campaigns Intelligence Hub

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Session Overview

Goal

Introduce the **Campaign Map and Integration Tool** as an approach to support campaign integration decision-making and provide **Nigeria's perspective** from testing the tool

Presenters

Aline Benson, MPH

- Senior Associate, Linksbridge
- Campaign Hub Support Liaison

Zaiyanatu Abubakar Umar, MPH

- Technical Assistant, Office of the Coordinating Minister of Health and Social Welfare, Nigeria Federal Ministry of Health
- Nigeria CAS Focal Point

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Background

As the Health Campaign Effectiveness (HCE) Coalition's data partner, the Linksbridge team has managed the Campaign Hub, a **cross-program campaign calendar database**, since 2019. Programs include malaria, PC-NTDs, nutrition, and vaccines.

This database was **used to support Nigeria and Ethiopia**, HCE's Collaborative Action Strategy (CAS) focus countries, to aid in two CAS recommendations:

1. Identify campaigns and domains for collaboration and integration
2. Develop a multi-year, cross-campaign integrated work plan and schedule (e.g., calendar) for campaigns

Nigeria Campaign Mapping and Integration Tool

Country Request

Nigeria's CAS team requested support to **map campaigns** occurring in the next three years **to inform program implementation for national-level program stakeholders.** Teams expressed the need to:

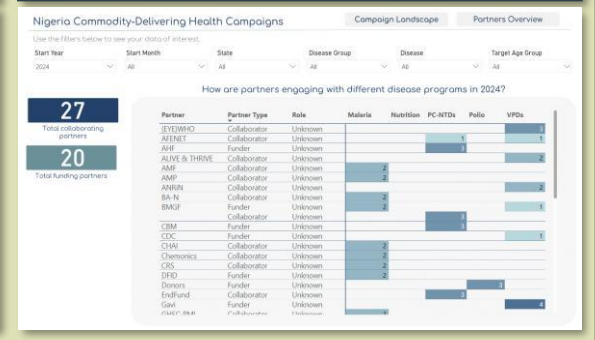
1. Harmonize campaign planning **data management** across programs
2. List **stakeholders** involved in campaign planning, funding, and delivery
3. Highlight potential opportunities for **collaboration and integration**

Proposed Solution

Part 1: Campaign Mapping

View 1: Campaign Mapping

View 2: Stakeholder Mapping



Maps all campaigns and campaign details to answer:

- **What** campaigns are happening and **when**?
- **Where** and **who** are the campaigns targeting?
- Who is **funding** the campaigns?

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Nigeria Campaign Mapping and Integration Tool

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Nigeria's CAS team requested support to **map campaigns** occurring in the next three years **to inform program implementation for national-level program stakeholders.** Teams expressed the need to:

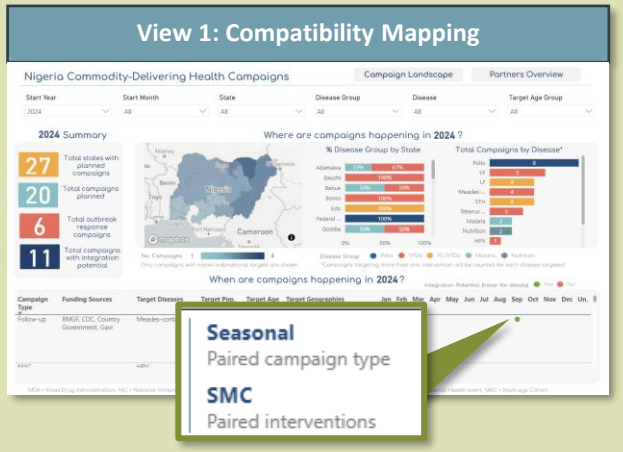
1. Harmonize campaign planning **data management** across programs
2. List **stakeholders** involved in campaign planning, funding, and delivery
3. Highlight potential opportunities for **collaboration and integration**

Proposed Solution

Part 2: Identifying Integration Opportunities

Uses an algorithm to identify optimal integration opportunities between campaigns based on:

1. **Target demographic**: Target population age and geographies
2. **Start date**: +/-4 weeks from the original start date
3. **Historical combinations**: integration has occurred historically



To answer questions like:

- Which campaigns have **integration potential**?

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Nigeria Commodity-Delivering Health Campaigns

Campaign Landscape | Partners Overview | Zoom In: By Program

Start Year	Start Month	State	Disease Group	Disease	Target Age Range
2025	All	All	All	All	All

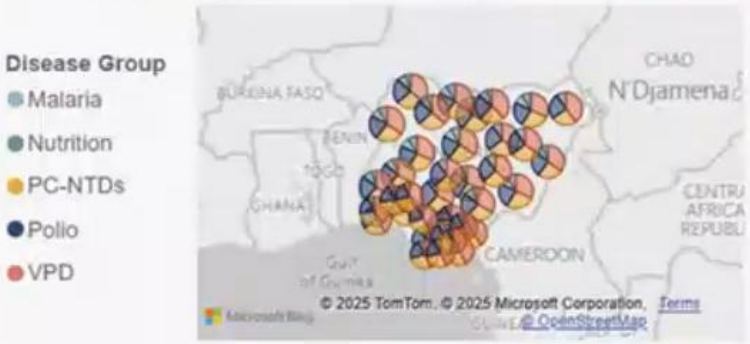
2025 summary

- **37** Total states with planned campaigns
- **23** Total campaigns planned
- **6** Total outbreak response campaigns
- **19** Total campaigns with integration potential

Where are campaigns happening in 2025?

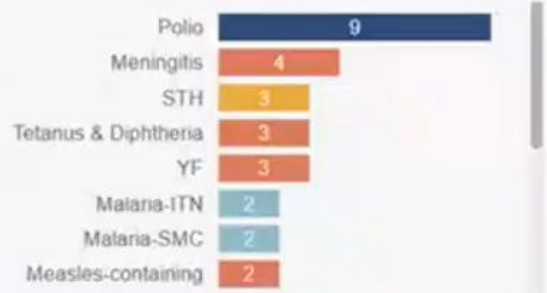
Percent of Campaigns by Program and State

Only campaigns with known subnational targets are shown



Total Campaigns by Disease*

**Campaigns targeting more than one intervention will be counted for each disease targeted*



When are campaigns happening in 2025?

Integration Potential: Yes | No | Unknown

Campaign Type	Funding Sources	Target Pop. (#)	Target Geographies	Intervention	Target Age (months)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Un.
Catch-up	BMGF, CDC, Country Government, Gavi	97,224,670	Adamawa, Bauchi, Benue, Borno, FCT, Gombe, Jigawa, Kaduna, Kano, Katsina, Kebbi, Kogi, Kwara, Nasarawa, Niger, Oyo, Plateau, Sokoto, Taraba, Yobe, Zamfara	MR	9-168										●			
				Other Routine Immunizations	0-23										●			
				HPV	108-168										●			
				STH	-										●			

MDA = Mass Drug Administration, NID = National Immunization Day, SNID = Sub-national Immunization Day, OR = Outbreak Response, CH/MH = Child/Maternal Health event, MAC = Multi-age Cohort

Country Perspectives from Nigeria

- How has the team **used the tool to support** your CAS work and overall campaign planning?
- Do you feel the tool has **created greater visibility and communication** between programs planning campaigns?
- What **improvements to the tool** would help make it more useful to the team's work in the future?

Learn more and share your perspective

- **Poster Title:** *Supporting Countries in Health Campaign Planning and Integration: Retrospective Analyses and Prospective Planning*

Poster in English & French
(Affiche en anglais et français)

Survey in English & French
(Enquête en anglais et français)

Access tools like the Nigeria Campaign Map and Integration Tool

- Aline Benson: aline.benson@linksbridge.com
- Contact form: https://www.linksbridge.com/contact-us

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Experience on integration of programmatic delivery

Ethiopia CAS-Health Campaign Effectiveness *Moving from Foundation to Implementation*

Country: Ethiopia

Name of presenter: Mr. Tesfahun Bishaw

10 min

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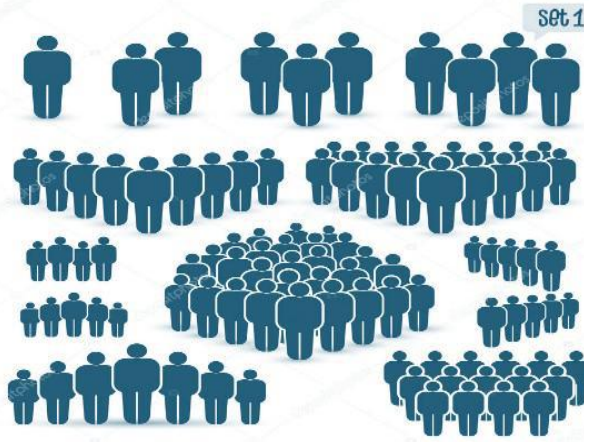
Outline

- ECAS Introduction and Progress
- Selected Health Campaigns
- Integration Opportunities
- Early Results
- Next Priority
- ECAS Support Areas Needed

COUNTRY BACKGROUND



POP: 120M

AREA

1.1M square kilometres

ADMINISTRATIVES

12 Regions **117 Zones**

2 City admins **1063 Weredas**

RURAL COMMUNITY

77%

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E-CAS Progress 1/2

- Ethiopia opted for CAS and MOH endorsed
- Feasibility assessment conducted and the result disseminated at national and global
- Stakeholders Identified (donors, IP, and government sectors)
- CAS socialization conducted
- NSC formed and strategic guidance will continue
- TWG -3 groups (Plan and Impel, MERLA & Finance –policy formed and produce national CAS strategy

E-CAS Progress 1/2

- Global recommendation customized to national context
- Campaigns calendar mapped (2025-2026)- nationally
- National CAS strategy developed
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- Regional CAS rollout and implementation guidelines ongoing
- Preparation completed for Measle with Nutrition upcoming May 2025 campaign.

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11 Customized Recommendations to Enhance Campaign Impact & Coordination in Ethiopia

Planning & Implementation

Rec #1a

Establish a multi-sectoral, cross-campaign National Steering Committee

Rec #1b

Identify campaigns and domains for collaboration and integration

Rec #1c

Develop a multi-year, cross-campaign workplan and schedule for campaigns

Rec #1d

Harmonize tools and operations (e.g., logistics, supply chain, microplanning) across campaigns

Rec #1e

Develop a coordinated and effective approach to enable active community engagement at all levels and phases

M&E/MERLA

Rec #2a

Develop a coordinated and collaborative cross-campaign MERLA strategy in Ethiopia

Rec #2b

Aligned with Ethiopia's MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness

Campaign Financing

Rec #3a

Create a comprehensive view of campaign financing at the country level by combining detailed campaign financing information from major funders and government, to enable better planning and execution

Rec #3b

Take incremental steps toward harmonizing and aligning campaign financing

Rec #3c

Harmonize and align incentive payment modalities and rates across campaigns

Rec #3d

Advance government role in campaign financing

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Campaigns list for integration in Ethiopia

1. Immunization/VPD

1. Measles/Rubella
2. Oral Poliovirus
3. HPV
4. Yellow Fever

2. Malaria

1. ITNs/LLINs
2. Environmental Management
3. Mass Fever Testing
4. Seasonal Malaria Chemoprevention (SMC)

3. NTDs

1. Schistosomiasis (SCH)
2. Soil-Transmitted Helminths (STH)
3. Lymphatic Filariasis (LF)
4. Onchocerciasis (ONC)
5. Trachoma (TRA)
6. Multi-Drug Administration (MDA)
7. Trachoma Trichiasis (TT)

4. Nutrition

1. Vitamin A Supplementation
2. Deworming
3. Nutrition Screening

5. NCDs

1. Hypertension and Diabetes Screening
2. Cataract Surgery
3. Breast and/or Cervical Cancer Screening

Selected five groups of campaigns

Fixed site	*House to house*	*School*	*Community based*	
• Immunization/ measles • Nutrition • NCD screenings	• Immunization/ polio • Malaria spraying • Nutrition	• NTD (schisto, STH, STP) • NCD screenings • HPV • Adolescent nutrition	• NTD (LF, Onco) • NCD screenings • Malaria (ITN, SMC)	• NTD (Trachoma, MDAs) • TT screenings • NCD screenings • Malaria (ITN, SMC) • Nutrition

Integration Opportunities

Training

Manuals/SOP/ Job aids

SBCC/ Communication

Data collection tools/reporting

Logistics

Supervision

Microplanning

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Early Results

- In February 2025, an Integrated Polio Campaign was conducted and 14 million Child vaccinated for polio, 61,000 zero dose children vaccinated, and 2000 club foot children identified & linked. (10 regions)
- Big catch-up vaccination, Malaria fever test, ITNS distribution, 6-59 months age screened for malnutrition, Vitamin A supplementation 6-59 months age, PLW screening, POP/fistula etc
- Joint efforts on the Polio Reactivation campaign and around 6,057 Zero Dose Integration (5 regions)
- The recent HPV vaccination campaign integrated with Adolescent Nutrition Screening, resulting in 45,096 screenings of 6.38 million girls during vaccinations. (November 18-22, 2024)

Next priority

- CAS roll out regional level
- Implementation guidelines finalization
- CAS Microplanning at regional level
- CAS implementation: Measle + Nutrition
- Resource mobilization –focus area ($2 M)
- Documentation of lesson learnt

ECAS Support Areas Needed

In order to properly execute CAS in Ethiopia, the Ministry of Health needs mobilization from partners and donors along three areas. CAS complementing existing initiatives (e.g. Big Catch Up, Lusaka Agenda), resources can be shared with other programs, brought together in the National Steering Committee.

Voice

- Partners and donors need to **commit** to CAS recommendations **and increased collaboration**
- Include CAS elements in your workplans and country-level strategies

Funding

- Needed to cover **Technical Assistance needs** (particularly in campaign financing and digitalization support) and the **organization of workshops**

Total amount identified in the costed implementation plan:
$2M

People

- Time from **country-level staff** is required to support improved coordination/collaboration with MoH, experiencing shortage of staffing
- Partners/donors can support the MoH with **project management**, **coordination platforms** and **logistics**

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Health Break/ Poster Sessions

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Global Programme to Eliminate Lymphatic Filariasis

Revised M&E guidance

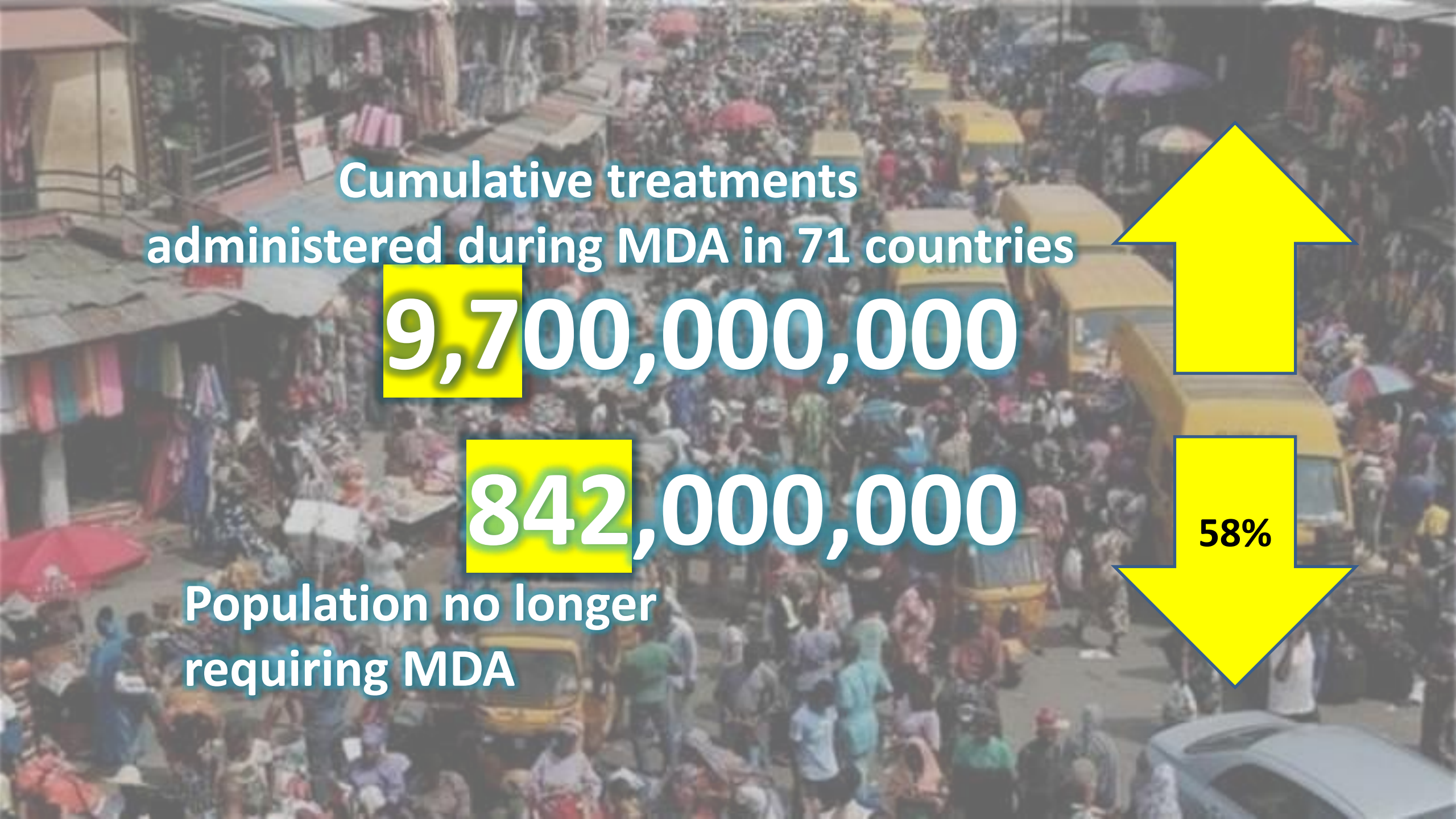
Jonathan King

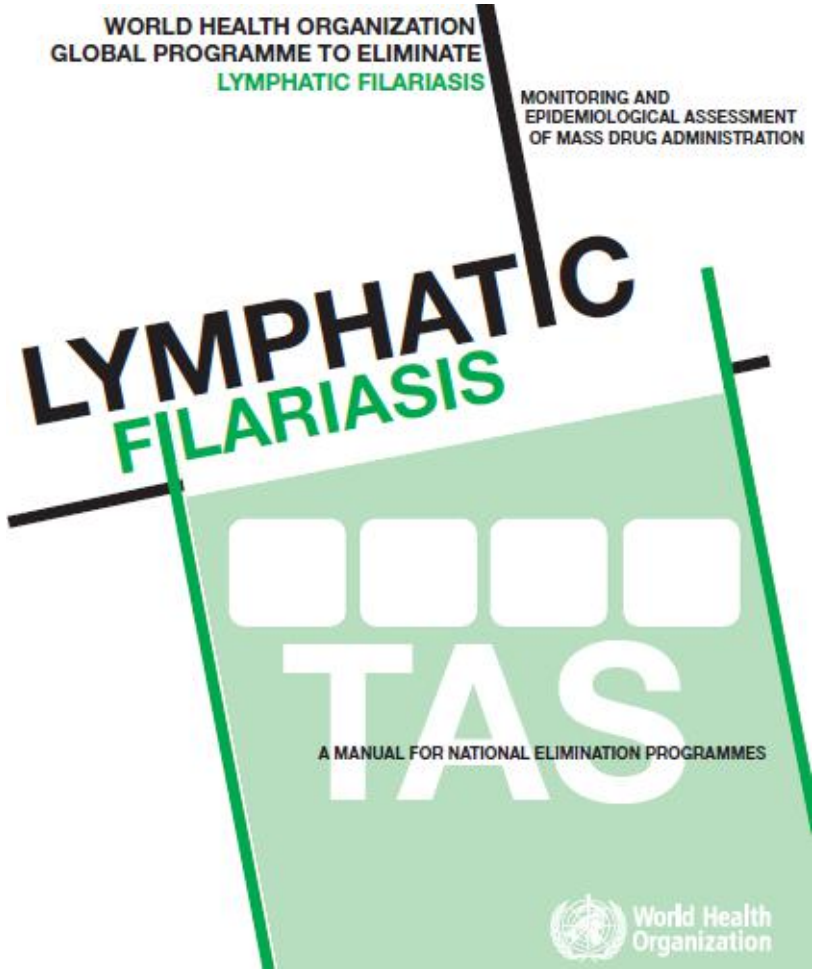
WHO Global Neglected Tropical Diseases Programme

World Health Organization

Lymphatic Filariasis: Elimination as a Public Health Problem: Status 2024

MDA not started	MDA started but not at scale	MDA scaled to all endemic districts	Post-MDA Surveillance	Post-Validation Surveillance
Gabon	Angola Central African Republic Nigeria Sudan *Papua New Guinea*	Burkina Faso, Chad, Côte d'Ivoire, Congo, Equatorial Guinea Ethiopia, Ghana, Guinea-Bissau, Guinea, Democratic Republic Congo, Liberia, *Madagascar*, Niger, Mozambique, Senegal, Sierra-Leone, South Sudan, Tanzania, *Zambia, Zimbabwe, Haiti, Guyana* *India, Indonesia, Myanmar, Nepal* *American Samoa French Polynesia, Tuvalu Fiji, Malaysia, New Caledonia Samoa, Philippines*	Benin, Eritrea, *Kenya* Cameroon, *Comoros*, Mali, Uganda, *Sao Tome & Principe* *Dominican Republic* *Brunei Darussalam* *FSM*	 *Egypt*, Yemen Togo, Malawi *Brazil, Timor-Leste Bangladesh, Maldives, Sri Lanka, Thailand* *Cambodia, Cook Islands Kiribati, Marshall Islands, Niue, Tonga, Lao PDR, Vanuatu, Palau, Vietnam, Wallis and Futuna*
1	5	34	11	21

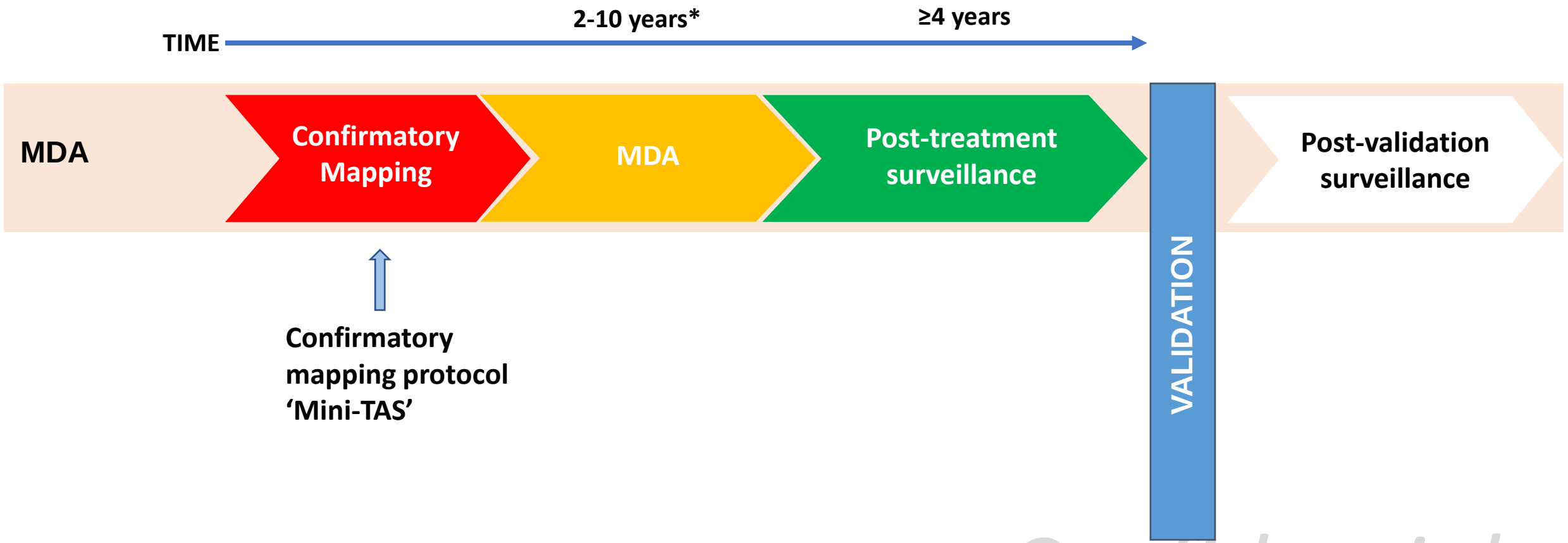

Cumulative treatments
administered during MDA in 71 countries
9,700,000,000
842,000,000
Population no longer
requiring MDA
58%



1st Edition 2011

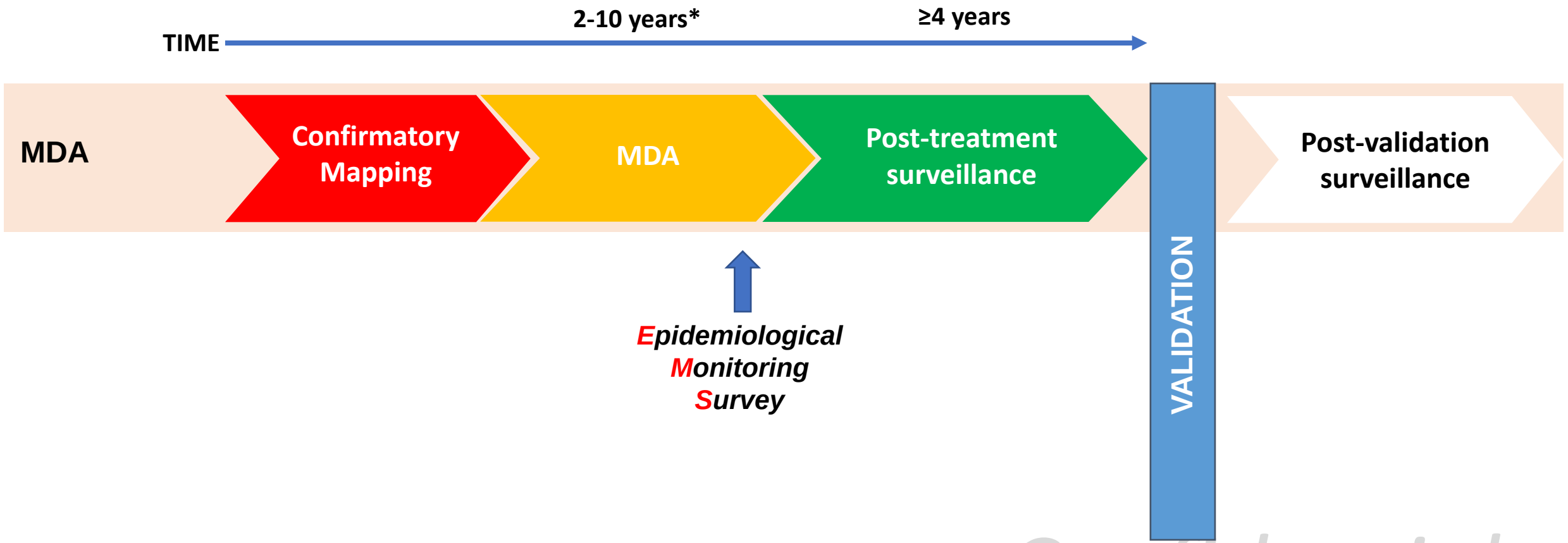
2nd Edition 2025

Revised GPELF Strategic Framework



*based on regimen and coverage achieved

Revised GPELF Strategic Framework



*based on regimen and coverage achieved

Pre-TAS is now Epidemiological Monitoring Survey (EMS)

Same function: impact monitoring; step 1 in stop-MDA strategy

Site selection: Purposeful selection of at least 2 highest risk communities per evaluation unit (EU size <500,000 population)

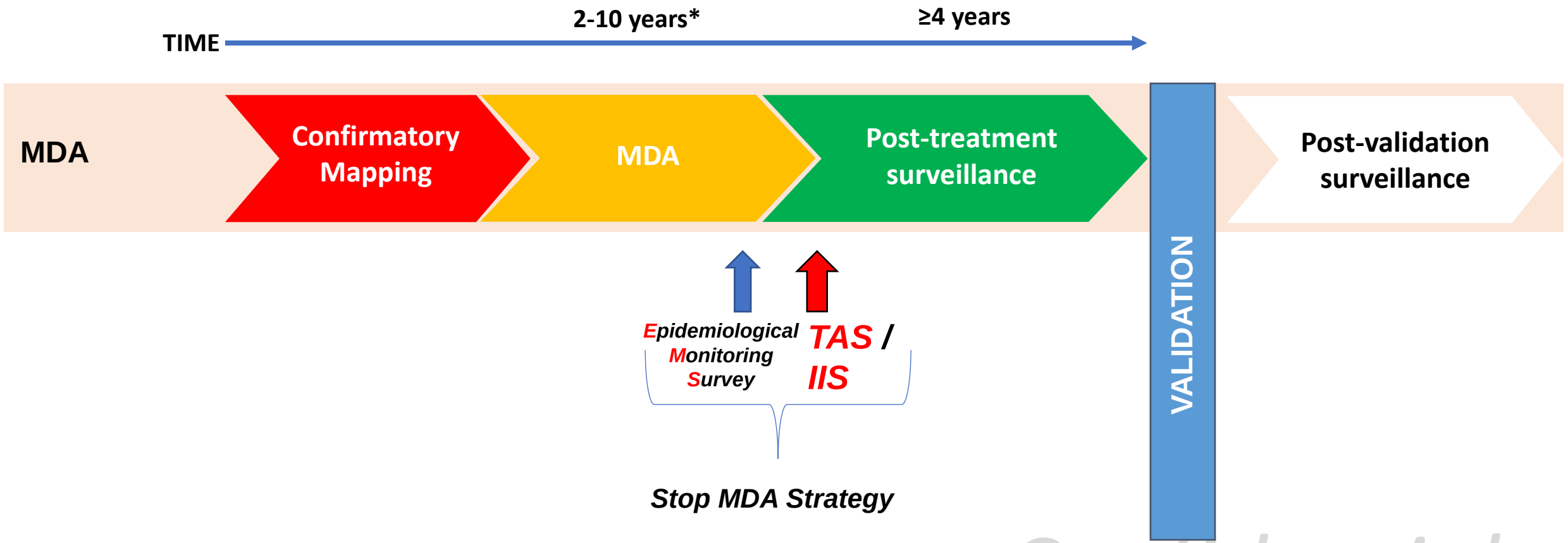
Sampling strategy: Random household selection

Sample size: at least 300 adults ≥20 years of age

Diagnostic: RDT finger prick blood; follow-up blood film on all RDT+

Decision rule: Ag <2% or Ag>2% and Mf<1% in each site in the EU then the EU is eligible for TAS or IIS

Revised GPELF Strategic Framework



*based on regimen and coverage achieved

New Transmission Assessment Survey (TAS)

Function: impact assessment survey, step 2 in the stop-MDA strategy

Site selection: cluster or systematic sampling of communities/schools for each evaluation unit (EU size <500,000 population)

Sampling strategy: randomized selection of children or households

Sample size: 1692* children 6-7 years of age **for all settings**

Diagnostic: RDT finger prick blood

Target threshold: **<1% Ag** (*W. bancrofti*)

Target population size (children aged 6–7 years)[a]	Systematic sampling design		Cluster sampling design		
	LQAS sample size (n)	Critical cut-off value	Sample size[b]	No. of clusters	Critical cut-off value
399	Census	< 0.01*n[c]	Cluster sampling is not recommended; use systematic sampling.		
400	284	1			
600	365	1			
800	438	1			
1000	50[illegible]	1	759	Divide the sample size for a cluster survey by the average number of target-age children per school/EA and round up to the nearest integer. If this integer is < 30, then the number of clusters is 30.	1
1200	52[illegible]	1	780		1
1400	53[illegible]	2	795		3
1600	59[illegible]	2	891		3
2000	60[illegible]	2	909		3
2400	61[illegible]	2	1228		4
2800	678	2	1356		4
3200	684	2	1368		4
3600	688	2	1376		4
4000	690	2	1380		4
5000	696	2	1392		4
6000	762	3	1524		6
8000	766	3	1532		6
10 000	770	3	1540		6
14 000	774	3	1548		6
18 000	776	3	1552		6
24 000	778	3	1556		6
30 000	778	3	1556		6
40 000	842	3	1684		6
49 999	842	3	1684		6
≥50 000	846	3	1692		6

Note that the target population levels and sample size are unchanged from the previous table used for Anopheles and Culex

Target population size (children aged 6–7 years)[a]	Systematic sampling design		Cluster sampling design		
	LQAS sample size (n)	Critical cut-off value	Sample size[b]	No. of clusters	Critical cut-off value
399	Census	< 0.01*n[c]	Cluster sampling is not recommended; use systematic sampling.		
400	284	1			
600	365	1			
800	438	1			
1000	506	1			1
1200	520	1			1
1400	530	2			3
1600	594	2	891		3
2000	606	2	909		3
2400	614	2	1228		4
2800	678	2	1356		4
3200	684	2	1368		4
3600	688	2	1376		4
4000	690	2	1380		4
5000	696	2	1392		4
6000	762	3	1524		6
8000	766	3	1532		6
10 000	770	3	1540		6
14 000	774	3	1548		6
18 000	776	3	1552		6
24 000	778	3	1556		6
30 000	778	3	1556		6
40 000	842	3	1684		6
49 999	842	3	1684		6
≥50 000	846	3	1692		6

What has changed are the critical cut-off values.

e sample size for
r survey by the
umber of target-
age children per school/EA and round up to the nearest integer. If this integer is < 30, then the number of clusters is 30.

Introducing the IDA Impact Survey (IIS)

Function: impact assessment survey**,** step 2 in the stop-MDA strategy **where IDA is used**

Site selection: 30 clusters (communities) by probability proportional to estimated size per EU (EU size <500,000 population)

Sample size: 100-105 **adults ≥20 years** of age per cluster

Sampling strategy: segmentation of households, testing all adults

Diagnostic: RDT; follow-up **blood film on all RDT+**

Decision rule: **Mf <1%** in the EU, stop-MDA and follow-up in positive clusters

IIS: Sample Size and Critical Cut-off

Target population size in EU (adults aged ≥ 20 years)	Systematic sampling		Cluster sampling		
	Sample size	Critical cut-off value	Sample size	Average sample size per cluster	Critical cut-off value
5 000–5 999	2380	7	3570	119	11
6 000–6999	2400	7	3600	120	11
7000–9999	2500	7	3750	125	11
10 000–14 999	2760		4140	138	12
15 000–29 999	2820	8	4230	141	12
30 000–54 999	3100	9	4650	155	14
55 000–109 999	3120	9	4680	156	14
> 110 000	3140	9	4710	157	14

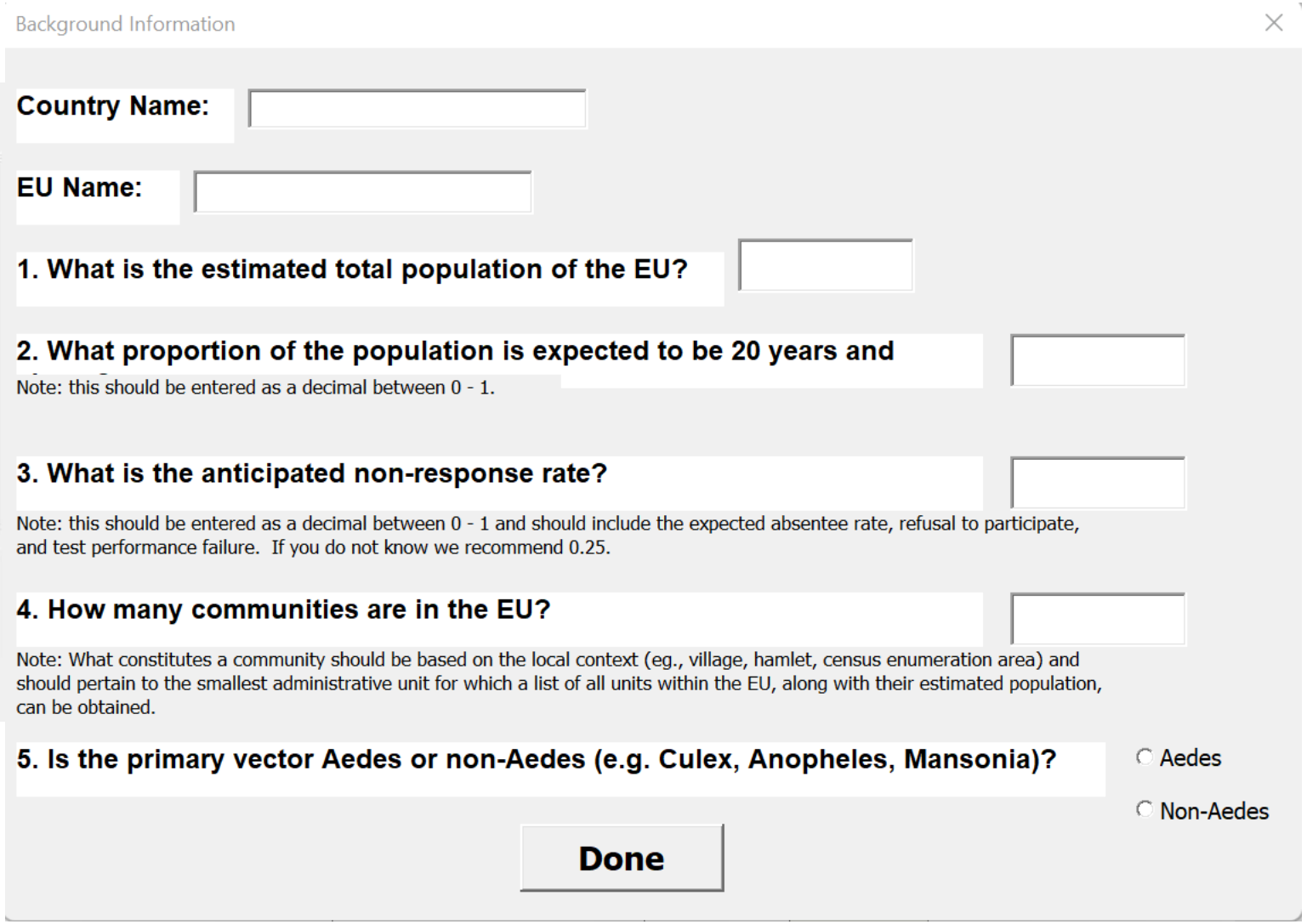
Larger sample size

IIS: Sample Size and Critical Cut-off

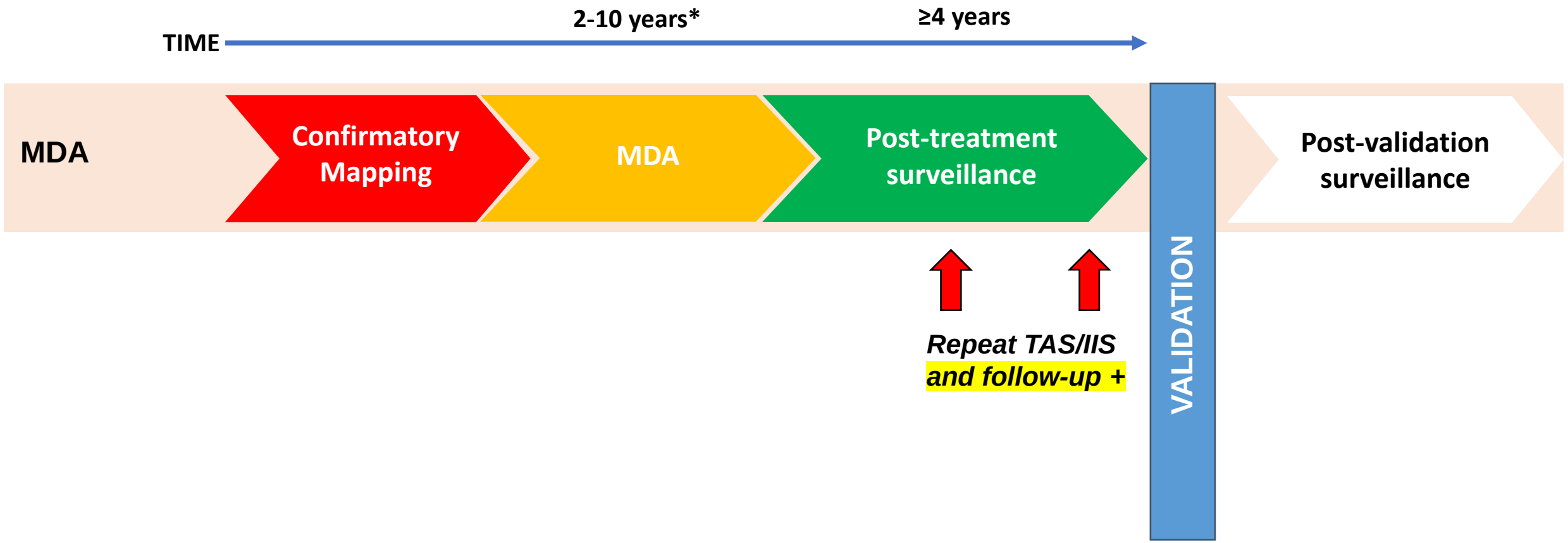
Target population size in EU (adults aged ≥ 20 years)	Systematic sampling		Cluster sampling		
	Sample size	Critical cut-off value	Sample size	Average sample size per cluster	Critical cut-off value
5 000–5 999	2380	7	3570	119	11
6 000–6999	2400	7	3600	120	11
7000–9999	2500	7	3750	125	11
10 000–14 999	2760	8	4140	138	12
15 000–29 999	2820	8	4		12
30 000–54 999	3100	9	4		14
55 000–109 999	3120	9	4680	156	14
> 110 000	3140	9	4710	157	14

Compare this value with the number of Mf + adults in the survey

IIS Survey Sample Builder



Revised GPELF Strategic Framework



*based on regimen and coverage achieved

New: Follow-up positives in TAS & IIS

- Guidance applies to **EUs that have passed** TAS/IIS but found positives

- Separate guidance for TAS3 / IIS3

Follow-up positives in TAS/IIS-1 and TAS/IIS-2

✓Treat any positive and family members then if in…

TAS: Clusters with 2 or more positives

or

IIS: Clusters exceed cluster level cut off

- ✓conduct 2 rounds targeted treatment in the cluster community
- ✓Proceed to next survey
- ✓Split EU for next survey if grouped geographically

Follow-up positives in TAS/IIS-3

✓Treat any positive and family members then if in…

TAS: Clusters with 2 or more positives

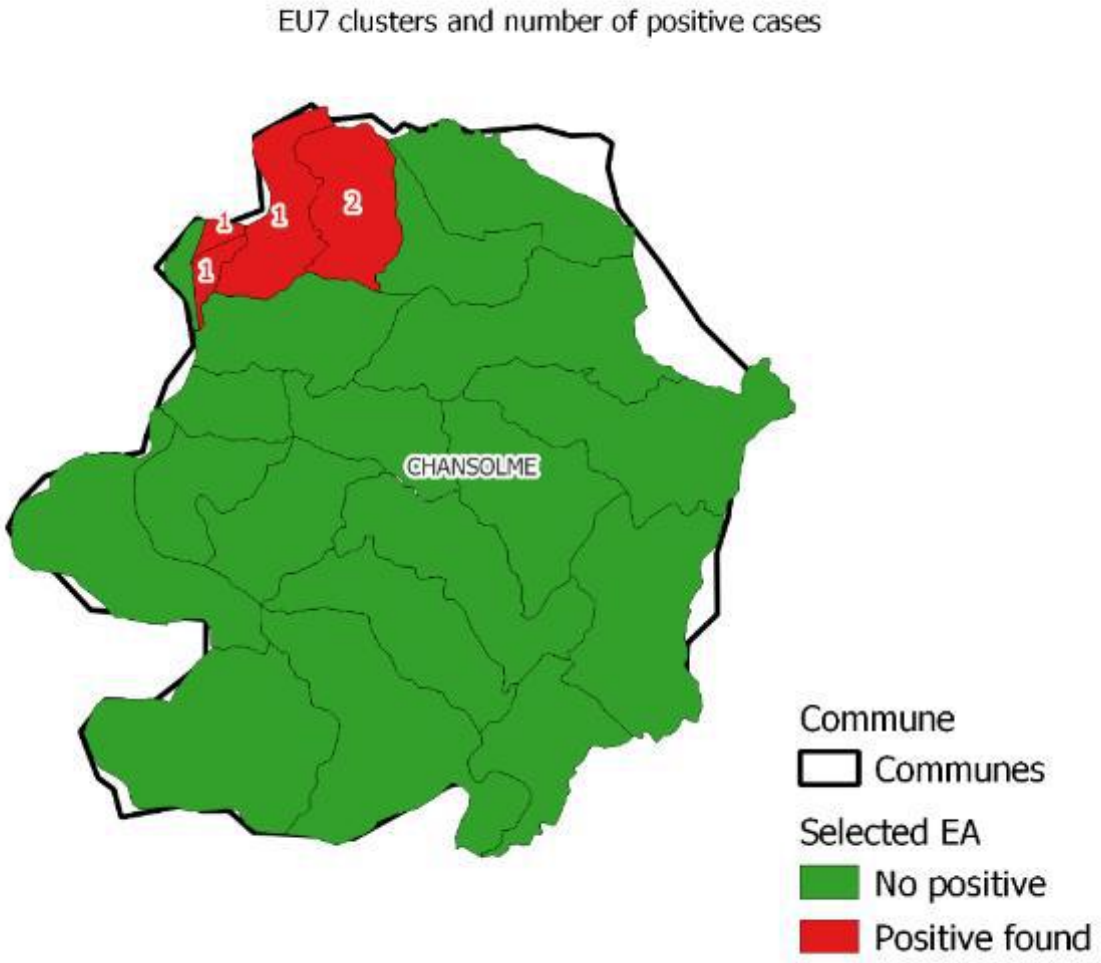
or

IIS: Clusters exceed cluster level cut off

- ✓conduct 2 rounds targeted treatment in the cluster community
- ✓Split EU if grouped geographically
- ✓Measure impact with EMS methodology and stop treatment if <1% Mf

Case Studies – Haiti - Chansolme (Culex) TAS3

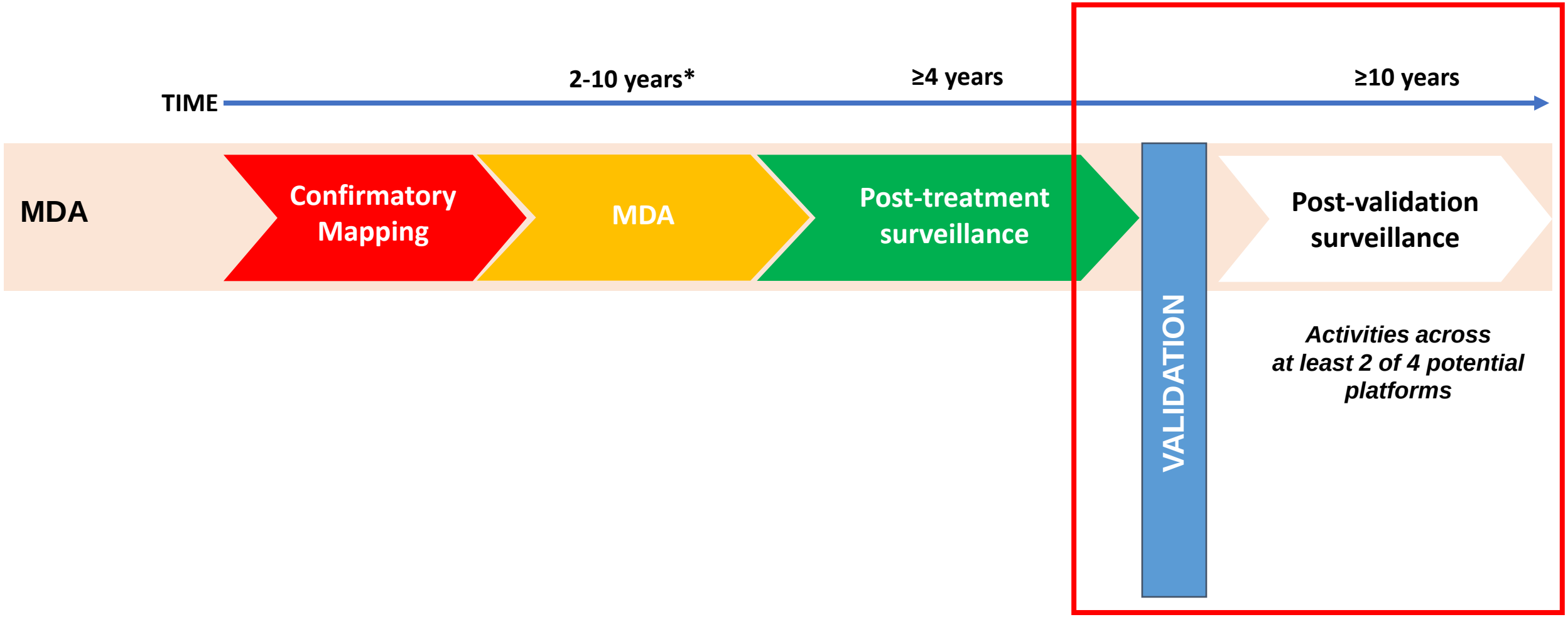
- CCV=6 vs FTS+ = 5
- All FTS+ clustered in small peri-urban area
- Decided to split into 2 EU's
  - One passed
  - Other 2 rounds of IDA plus EMS



A few other minor changes

- No inclusion of specific diagnostic test names (because new tests are available)
- Migrants in surveys (not to be excluded)
- No repeat testing of RDT positives in any survey (only repeat if invalid)
- Timing of surveys –
  - EMS 6 months after 2-drug MDA
  - EMS 9 months after IDA
  - TAS/IIS can proceed immediately after meeting EMS criteria

Revised GPELF Strategic Framework



*based on regimen and coverage achieved

Implement at least 2 platforms below for PVS

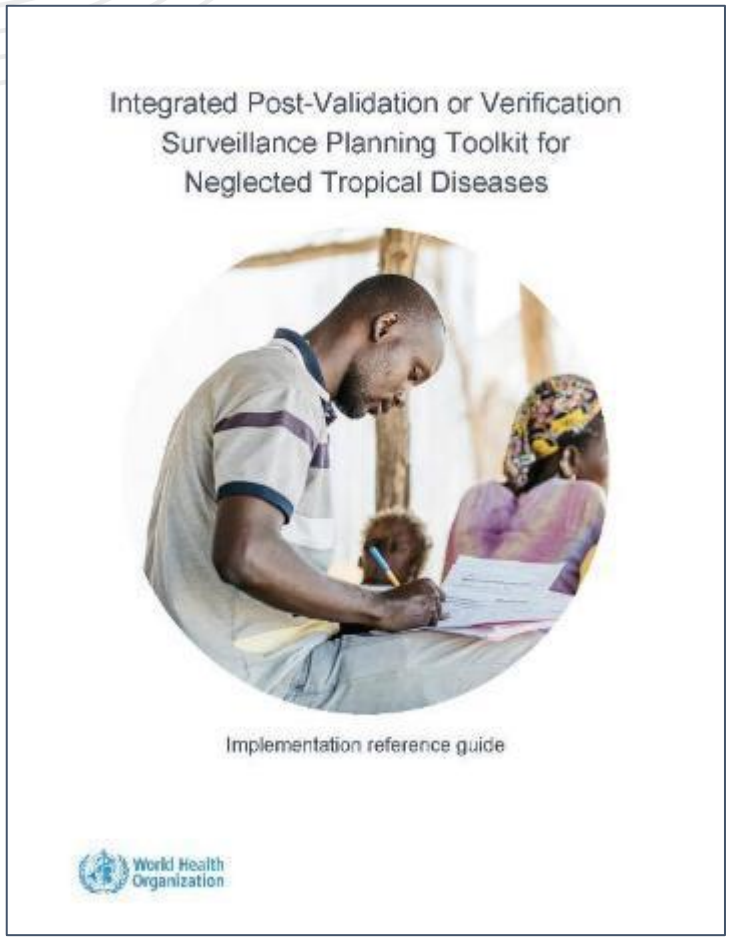
1. Health facility screening (LF is **integrated**)
2. Existing standardized surveys (LF is **integrated**)
3. Xenomonitoring (can be **integrated**)
4. Targeted surveys (LF is the primary purpose, other NTDs **integrated**)

When to conduct PVS?

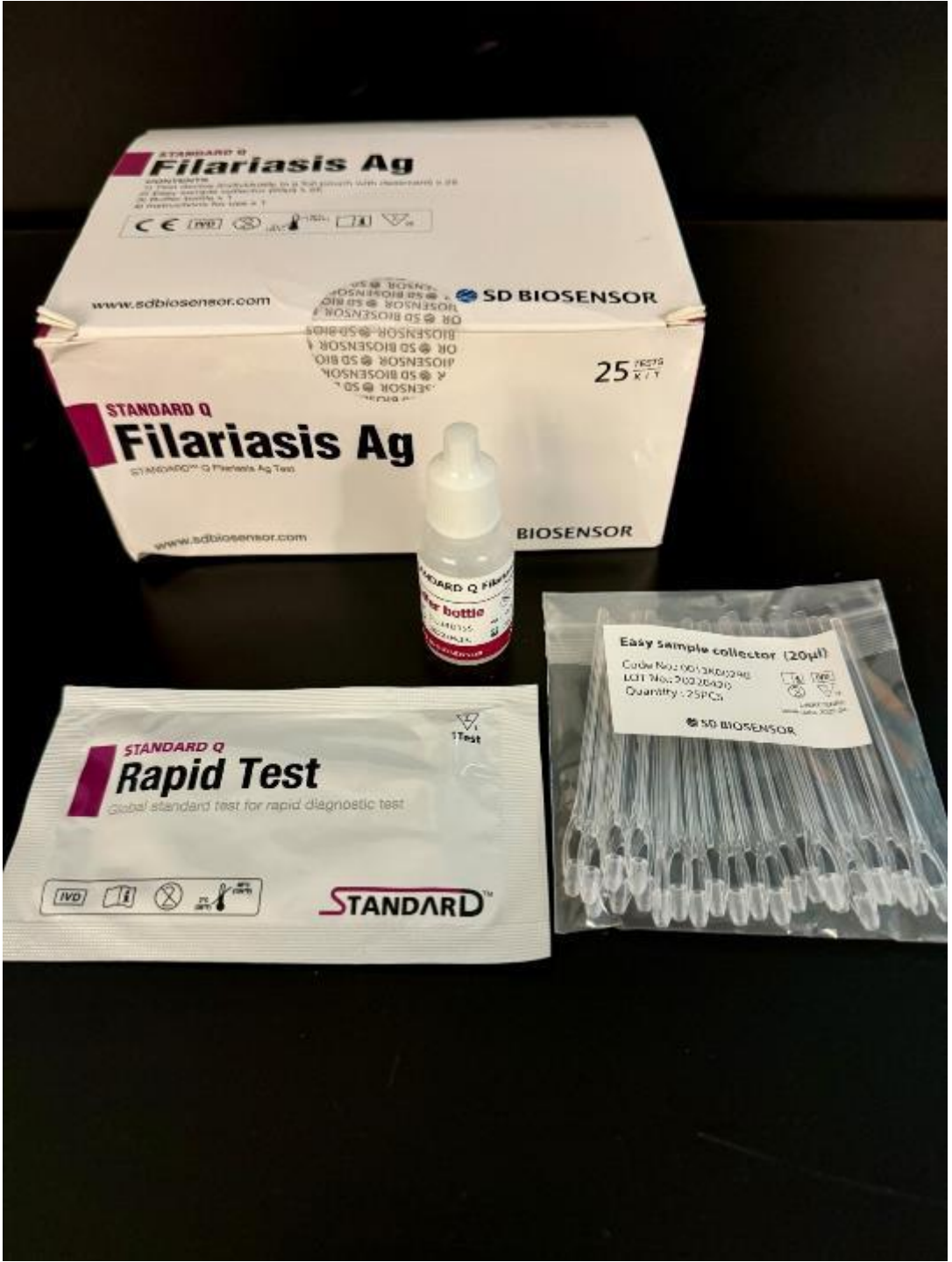
1. Once national validation has been achieved … however
2. Pilot ongoing surveillance in EUs that have passed TAS3

- Prioritize activities in EUs considered **highest risk** for resurgence (high baseline, TAS positives, border districts, clinical disease)
- Integrate with other adjunct measures in the interim (vector control)

Integrated PVS Planning toolkit for NTDs – Q2 2025

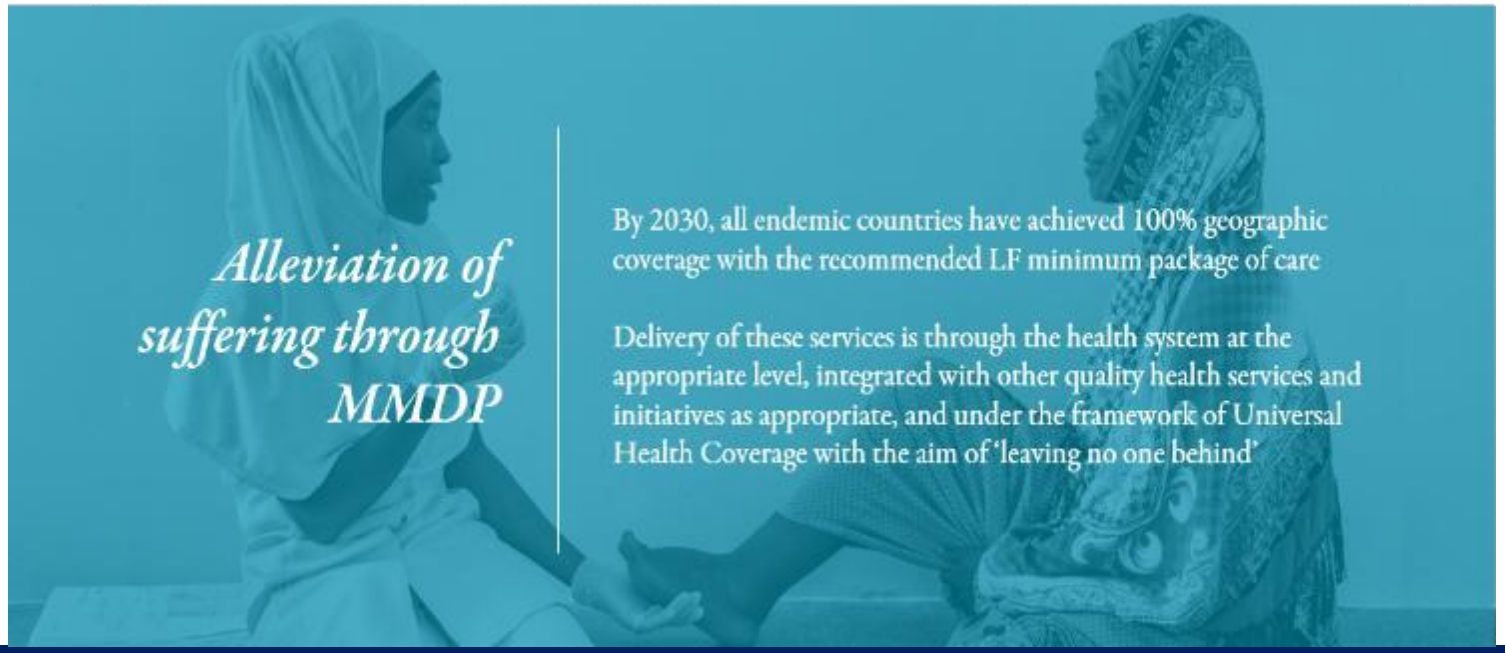


- **Purpose**: support national program decision-making on how to best leverage platforms and resources currently available in country to monitor for recrudescence of eliminated NTDs
- **Target audiences**: National NTD programs, national surveillance officers and MOH, global stakeholders supporting elimination efforts.
- **Timeline for toolkit use**: most useful during **post-MDA surveillance** & during preparation of dossier submission prior to being validated/verified.



SD Biosensor STANDARD™ Q Filariasis Antigen Test (QFAT)

- Rapid diagnostic test used for the qualitative detection of *Wuchereria bancrofti* antigen
- Validated in multi-site laboratory and field evaluations
- Data reviewed by LF subgroup of the WHO Diagnostic Technical Advisory Group (DTAG)
- **First NTD test to be approved** by the WHO Expert Review Panel for Diagnostic Products (ERPD)
- QFAT currently available for purchase; Countries can now request WHO to donate for LF surveys



Thank you.
Please ask questions
kingj@who.int

Overview of the Monitoring and Evaluation framework for Schistosomiasis and STH control programmes

Dr Denise Mupfasoni
Dr Amadou Garba

World Health Organization
African Region

ESPEN
EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

Annual Meeting of NTD National Programme Managers in the WHO African Region

NTD road map 2021-2030

Target, sub-targets and milestones

Schistosomiasis

WHO 2030 target, sub-targets and milestones

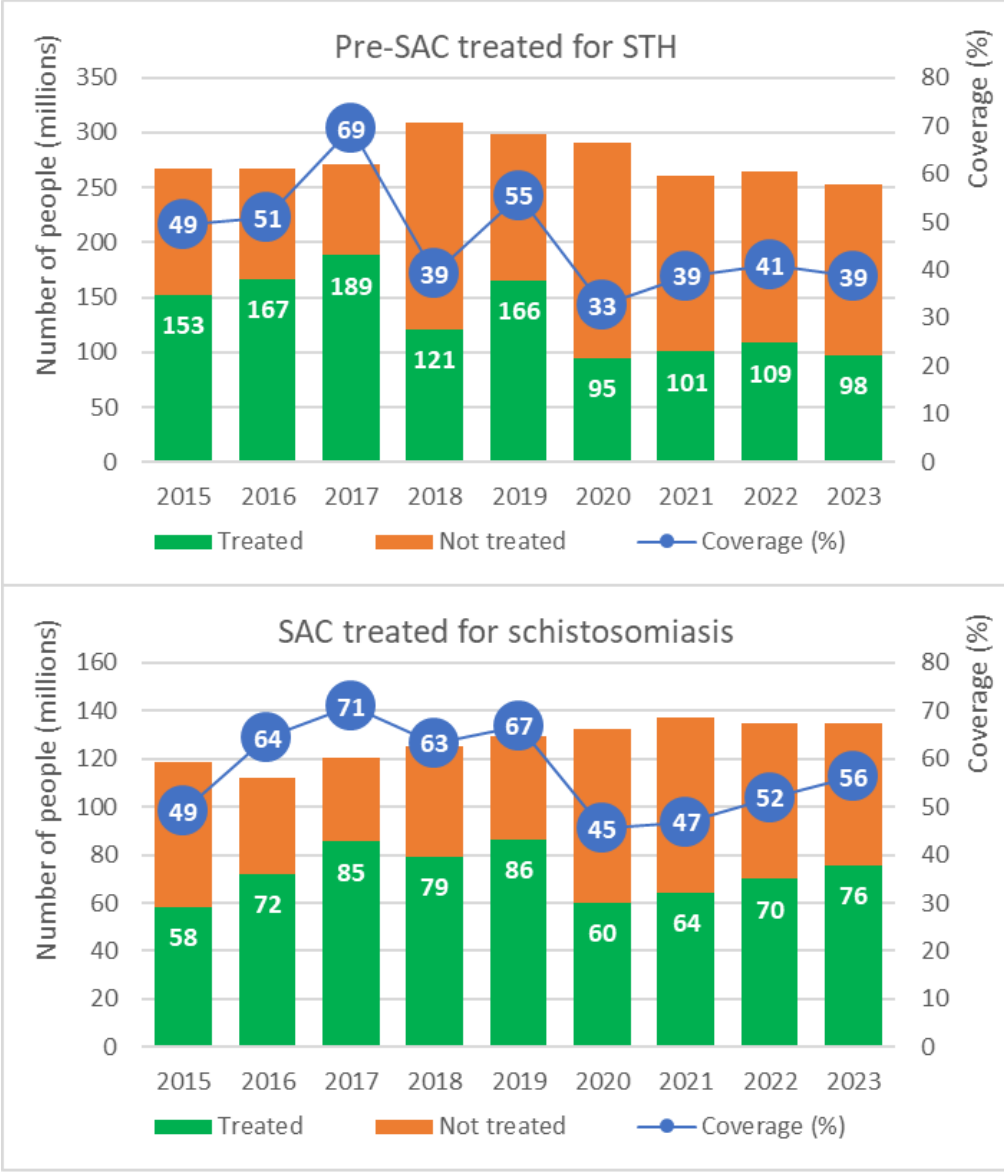
Indicator	2020 (provisional estimate)	2023	2025	2030
Number of countries validated for elimination as a public health problem (currently defined as <1% proportion of heavy intensity schistosomiasis infections)	0	49/78 (63%)	69/78 (88%)	78/78 (100%)
Number of countries where absence of infection in humans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

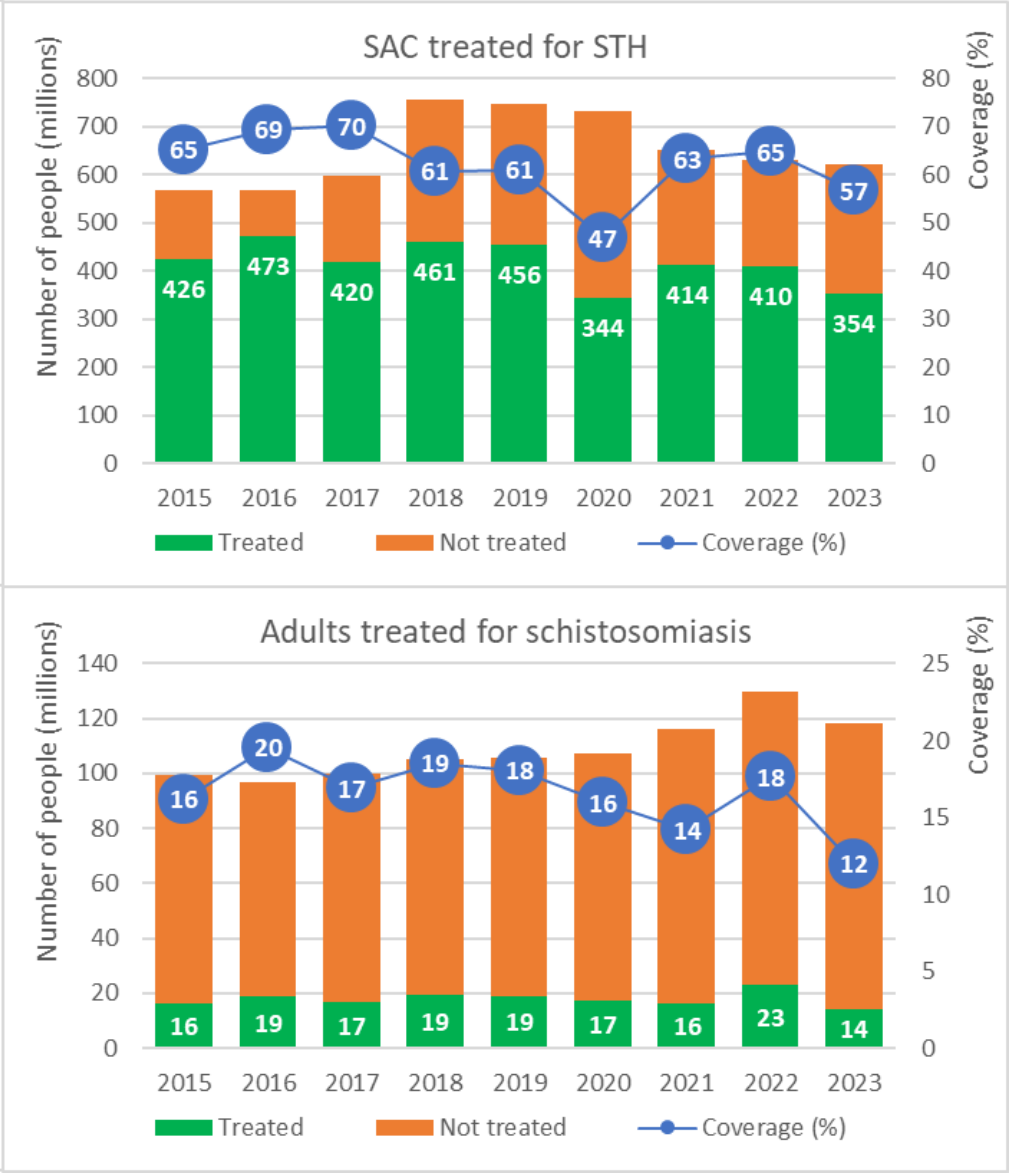
STH

WHO 2030 target, sub-targets and milestones

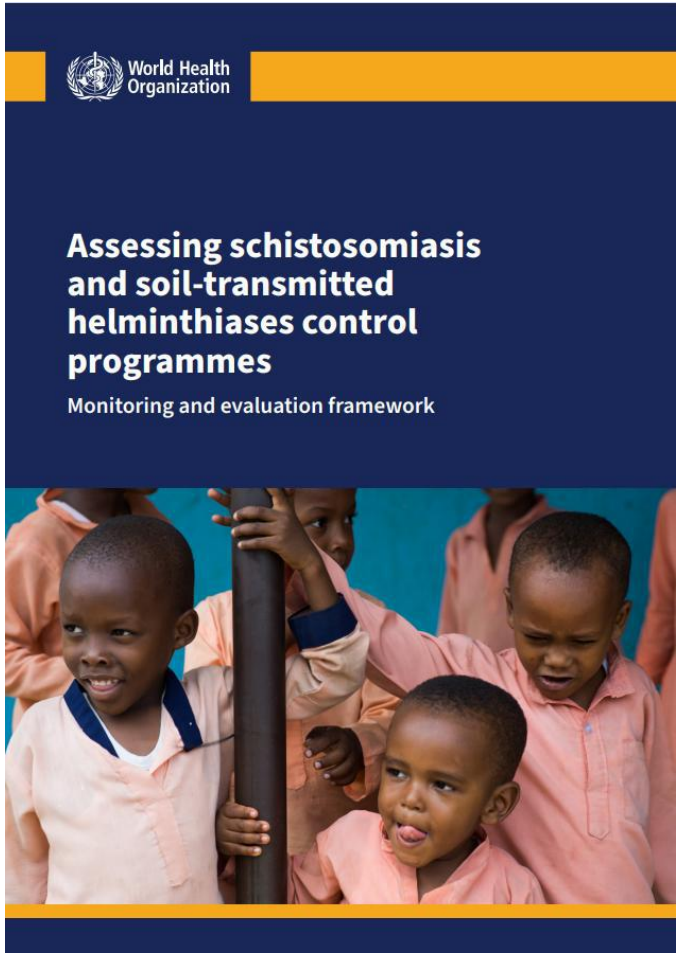
Indicator[1]	2020 (baseline)	2023	2025	2030
Number of countries validated for elimination as a public health problem (defined as <2% proportion of soil-transmitted helminth infections of moderate and heavy intensity due to *Ascaris lumbricoides*, *Trichuris trichiura*, *Necator americanus* and *Ancylostoma 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%)

Progress of PC for STH and schistosomiasis and global coverage (%) 2015-2023





Objectives



- Objective :Provide guidance to managers of soil-transmitted helminthiasis and schistosomiasis control programmes towards the elimination of these diseases as public health problems
- Guidance on :
  - the timing in which to conduct monitoring activities
  - the indicators to be collected, their calculation and survey methodologies to use
  - How to interpret the result (to select the appropriate treatment and allocate resources efficiently)

Monitoring and evaluation manual development process

- M and E manual as Global Public Health Good
- Establishment of a technical advisory group for schistosomiasis and STH (TAGSS) and sub-working groups
- Meetings of the working groups and review of the drafts of the document
- Meeting of programme managers to discuss the prefinal draft
- Meeting of the technical advisory group for validation of the final draft
- Presentation of the draft at meetings to get the feedback of end users
- Integration of the endusers comments
- Submission of the final draft for peer review (3 experts)
- Integration of the comments of the peer reviewers
- TAGSS final check
- Editing and publication

What changes as a result of applying the guidelines in this manual?

The manual is designed to help program managers and partners:

- Conduct M&E that is attainable and affordable for their unique country context
- Simplify decision-making on who to offer PC and at what frequency in a mature programme where a lot of worm control has been conducted
- The manual have been developed to be sufficiently **flexible** to allow the incorporation of new technologies as they become available
- Context is everything in NTDs: The guidelines should not 'paint ourselves into a corner' by being prescriptive or 'one-size-fits-all'

Note:

- Treatment does not get withdrawn following this guidance: treatment frequency changes from current levels to **annual, once in two or three years**, and then to a periodic event or venue-based approach as risk of morbidity is shown to have decreased
- Applying these guidance will help to **optimize the global program to allocate donated drug** according to need. They also set countries up to transition to local procurement of medicine if needed if insufficient drug is donated

What the manual is and what it is not

- The manual focuses very much on ‘WHAT’ to do, but does not give a single ‘HOW’ to do it. Several different approaches to data collection are presented. Different programs have different levels of staffing and resources and a form of M&E should be available for all budgets
- The manual will help programme managers interpret their data and apply it to their unique programme context
- The manual is innovative in that it does not advocate for a single approach or give a set of instructions on how to conduct M&E
- The manual will not help you decide when to STOP treatment for schistosomiasis and STH
- Separate manuals for validation of Elimination as a Public Health Problem (EPHP) are under development for SCH and STH (‘divorce with cause’)

Outline of the document

Acknowledgments

Terminology and definitions

1 Objective, main messages and notes regarding this document

2 Background

3. Control interventions

4. Overview of programme phases and monitoring and evaluation activities

5. Baseline survey

6 Monitoring control interventions

7. Identifying and managing hotspots for SCH

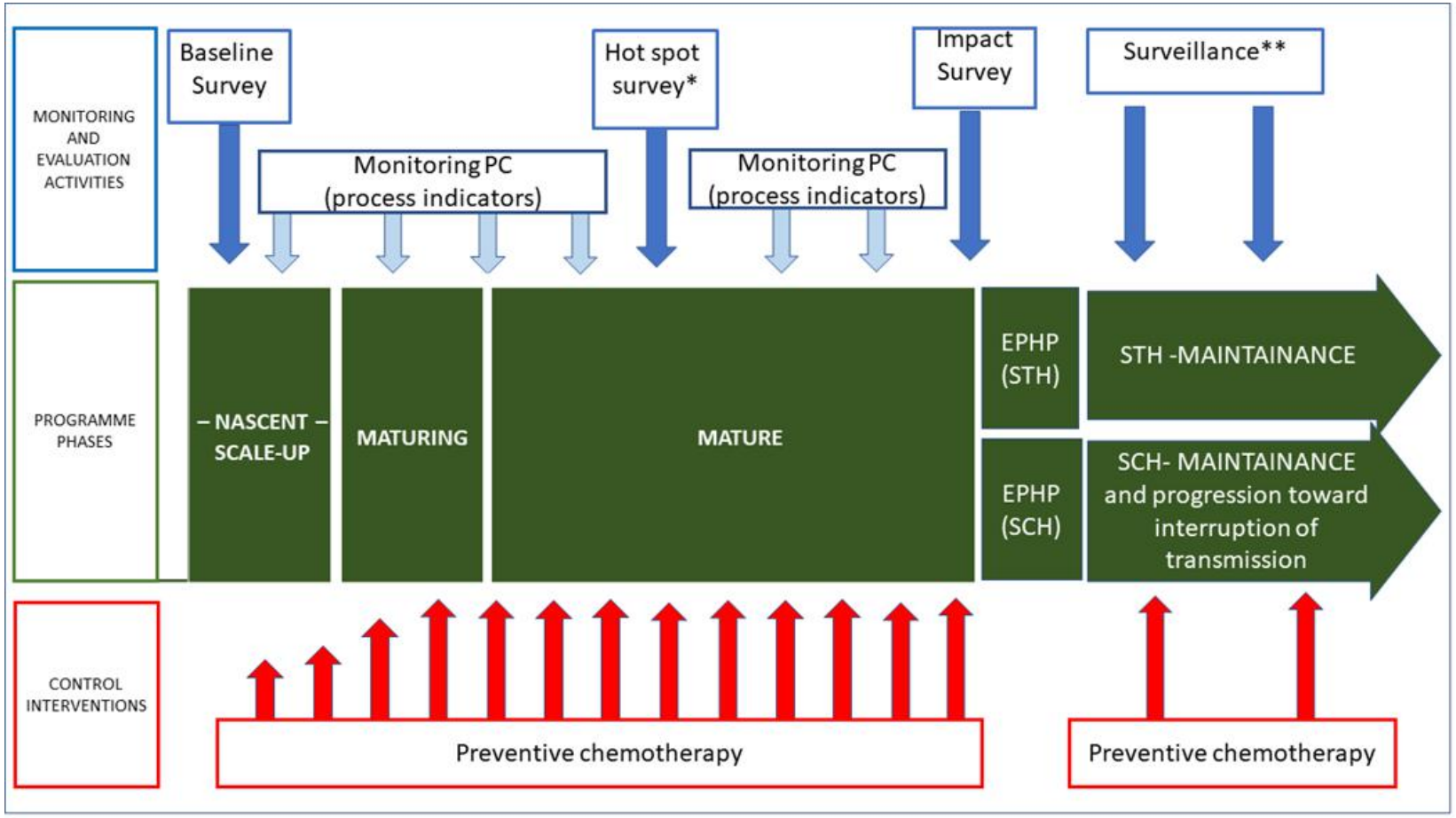
8. Impact assessment

9 Surveillance

References

Annexes

Phases of the control and elimination of SCH and STH as a public health problem programme



Key parasitological and morbidity indicators collected during baseline and impact assessments

Parasitological indicator	Use	Calculation	Expectations or goals
Prevalence of any STH infection	To evaluate the proportion of individuals infected and to identify the appropriate control intervention	Numerator: number of individuals testing positive Denominator: number of individuals providing a specimen	The prevalence of infection is progressively reduced, allowing a parallel adaptation of the frequency of PC. For SCH, this indicator can be used to identify potential hotspots.
Prevalence of any SCH infection			
Prevalence of STH infection, by species	To evaluate if any STH species is more prevalent and to select the most appropriate medicine for the PC intervention	Numerator: number of individuals testing positive for each species Denominator: number of individuals providing a specimen	The prevalence of infection is progressively reduced, allowing a parallel adaptation of the frequency of PC.
Prevalence of SCH infection, by species	To evaluate the need for additional activities (i.e. targeting female genital schistosomiasis in the case of S. haematobium)		Additional control activities are implemented to control female genital schistosomiasis in areas of high prevalence of S. haematobium (i.e. training of health personnel, screening of women, health education).
Morbidity indicators			
Prevalence of any MHI infection due to STH	To evaluate the proportion of individuals with potential morbidity attributable to STH and SCH To evaluate the progression of the programme towards EPHP of STH and SCH	Numerator: number of individuals with MHI infection Denominator: number of individuals providing a specimen	The prevalence of MHI or HI infection is progressively reduced. The diseases are EPHPs.
Prevalence of any HI infection due to SCH		Numerator: number of individuals with HI infection Denominator: number of individuals providing a specimen	

Additional indicators of morbidity in schistosomiasis and soil-transmitted helminthiases control programmes

Infection	Additional indicator	Method
Soil-transmitted helminthiases and schistosomiasis	Mean STH/SCH epg in the population	Arithmetic or geometric
Urogenital schistosomiasis	Prevalence of blood in the urine	Reporting of blood in urine, visual examination or reagent strips
	Prevalence of lesions in the urinary tract	Ultrasound (WHO, 1996)
	Prevalence of genital manifestations of schistosomiasis	Clinical examination, colposcopy, ultrasound of pelvic organs
Intestinal schistosomiasis	Prevalence of blood in stool (including persistent bloody diarrhoea)	Reporting, visual observation, reagent strips
	Prevalence of lesions in the liver, spleen and portal veins, presence of ascites.	Ultrasound (WHO, 1996)

Process indicators, their calculation and use, and expectations or goals

Use	Process indicator	Calculation	Expectations or goals
To evaluate the efficiency of the drug procurement and storage process; to evaluate management of the drug supply	Drug quality and shelf-life	- Quality control (for non-donated medicines[a]) - shelf-life exceeds 2 years	Drug of appropriate quality received at least 2 years[b] before the expiration date
	Drug procurement[c]	Numerator: Quantity of the drug self-procured Denominator: Quantity of drug needed	The country becomes progressively self-sufficient in drug procurement
	Drug distribution at peripheral units	Numerator: Number of distribution points (schools /health units) receiving the drug supply in time and appropriate quantity for the drug administration Denominator: Total number of schools/health units targeted by the programme	≥ 95% of the participating distribution points received the drug(s) at the appropriate time and in adequate quantity
	Drug expiration	Numerator: Number of tablets expired in the central storage facility Denominator: Number of tablets procured	< 5% of tablets are expired
	Theoretical drug balance	Number of tablets procured – Number of tablets distributed	N/A
	Drug tablets lost or unaccounted for	Numerator: Theoretical drug balance – actual drug balance (i.e. stock) Denominator: Number of tablets procured	< 10%
To evaluate the efficiency of the distribution of supporting materials	Presence of tablet poles or weighing scales for praziquantel administration	Numerator: Number of distribution points (schools/health units) receiving drug administration tools on time and in appropriate quantity for the campaign Denominator: Total number of distribution points (schools/health units) covered by the programme	All schools/health units receiving praziquantel also received tablet poles or weighing scales for distribution
	Presence of reporting forms	Numerator: Number of distribution points receiving reporting forms on time and in appropriate quantity for the campaign Denominator: Total number of distribution points covered by the programme	All schools/health units received reporting forms
	Presence of health education materials	Numerator: Number of distribution points receiving health education materials on time and in appropriate quantity Denominator: Total number of distribution points covered by the programme	All schools/health units received education materials in time to organize health education sessions
	Presence of training materials	Numerator: Number of trainers receiving material on time and in appropriate quantity for organization of training sessions Denominator: Total number of distribution points (schools/health units)	All trainers received training materials in time to organize training sessions

Performance indicators, their calculation and use, and expectations or goals

Use	Performance indicator	Calculation	Expectations or goals
Evaluating the extent of the programme and its relevance in the school/health system	Percentage of distribution points (e.g. schools/ health units, communities) participating in the programme	Numerator: Number of distribution points (schools/health units, communities) participating Denominator: Total number of (schools/health units) in the targeted areas	≥ 90% of the points (schools /health units) in the area participated
To optimize the amount of medicine provided to the different distribution points (schools/health units)	Number of tablets administered	From programme forms (preferably electronic forms)	Each distribution point (schools/health units) received enough medicine < 10% of tablets are unused
	Number of distribution points (schools /health units, communities) with an insufficient amount of medicine		
	Number of unused tablets		
Determining the proportion of individuals receiving the intervention	Coverage	Numerator: Number of individuals receiving the medicine(s) (by group at risk) Denominator: Total number of individuals in the area of intervention (by group at risk)	≥ 75% of individuals receiving the medicine in each group at risk

Other indicators

- Wash indicators

Indicator	Definition	Global target
Water supply	Proportion of population using basic drinking-water from an improved source[a]	100%
Sanitation	Proportion of population using improved facilities that are not shared with other households Proportion of population practicing open defecation	100% 0%
Hygiene	Proportion of population using hand-washing facilities with soap and water at home	100%

- Vector control indicators

Prevalence thresholds for preventive chemotherapy intervention for STH and SCH infections before any intervention

Soil-transmitted helminthiases	**< 20% prevalence**	**≥ 20 and < 50% prevalence**	**≥ 50% prevalence**
	No PC needed (Use clinical approach)	PC once a year targeting all groups at risk	PC twice a year targeting all groups at risk
Schistosomiasis	**< 10% prevalence**	**≥ 10 and < 50% prevalence**	**≥ 50% prevalence**
	- No PC needed (test and treat or clinical approach)	PC once a year for the entire population aged 2 years and older	PC once a year for the entire population aged 2 years and older

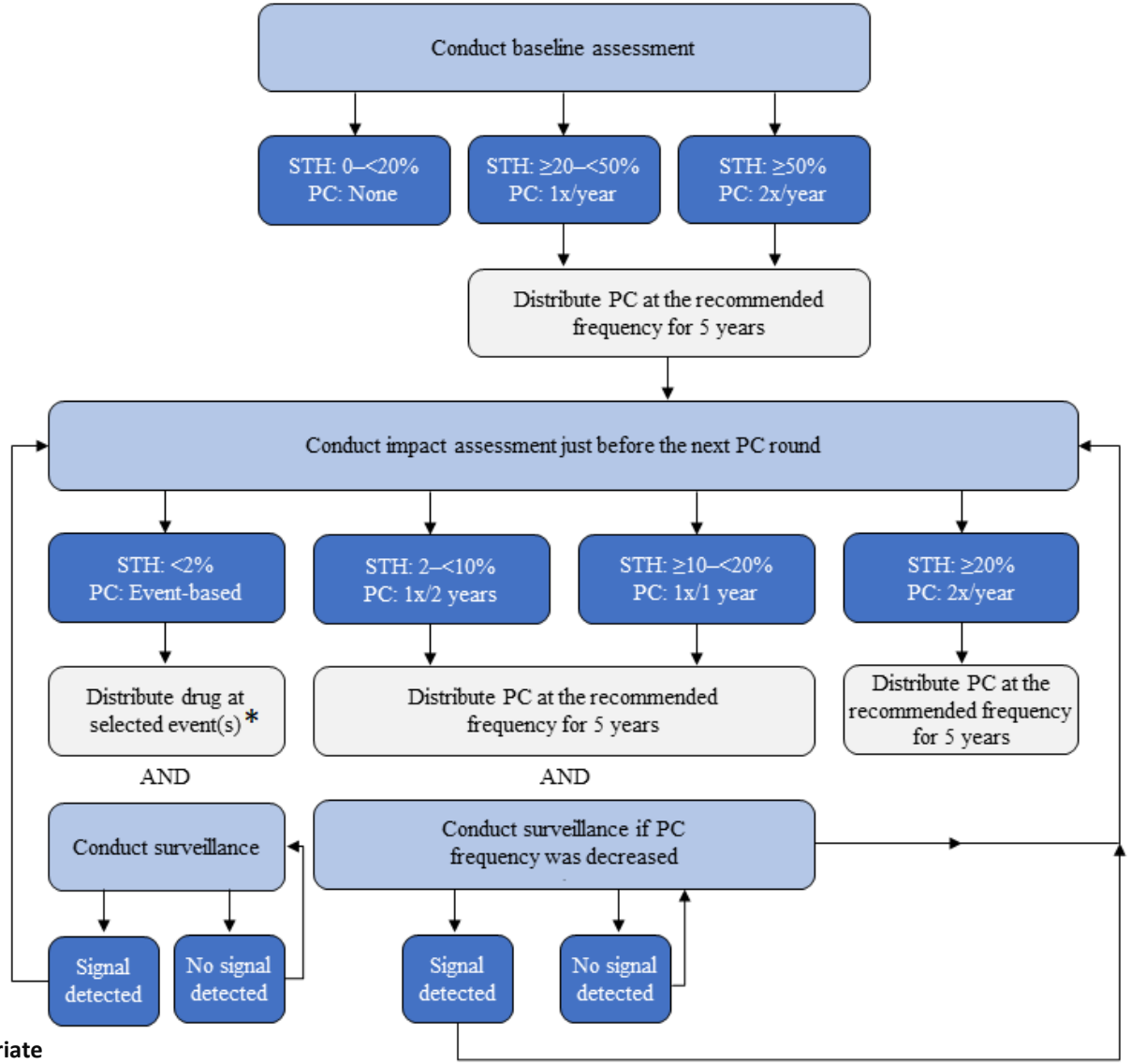
Prevalence thresholds for preventive chemotherapy intervention for STH and SCH after multiple years of intervention

STH					
Prevalence of infection	< 2%	≥ 2% and < 10%	≥ 10 and < 20%	≥ 20%	
Recommended PC frequency	Event-based	Once every 2 years targeting all groups at risk	Once a year targeting all groups at risk	Twice a year targeting all groups at risk	
SCH					
Prevalence of any intensity infection	< 10%		≥ 10%[b]	≥ 50%	
Recommended PC frequency	Maintain or reduce frequency[c]		Once a year	Twice a year	

Possible approaches to conducting surveys for STH/SCH epidemiological assessments

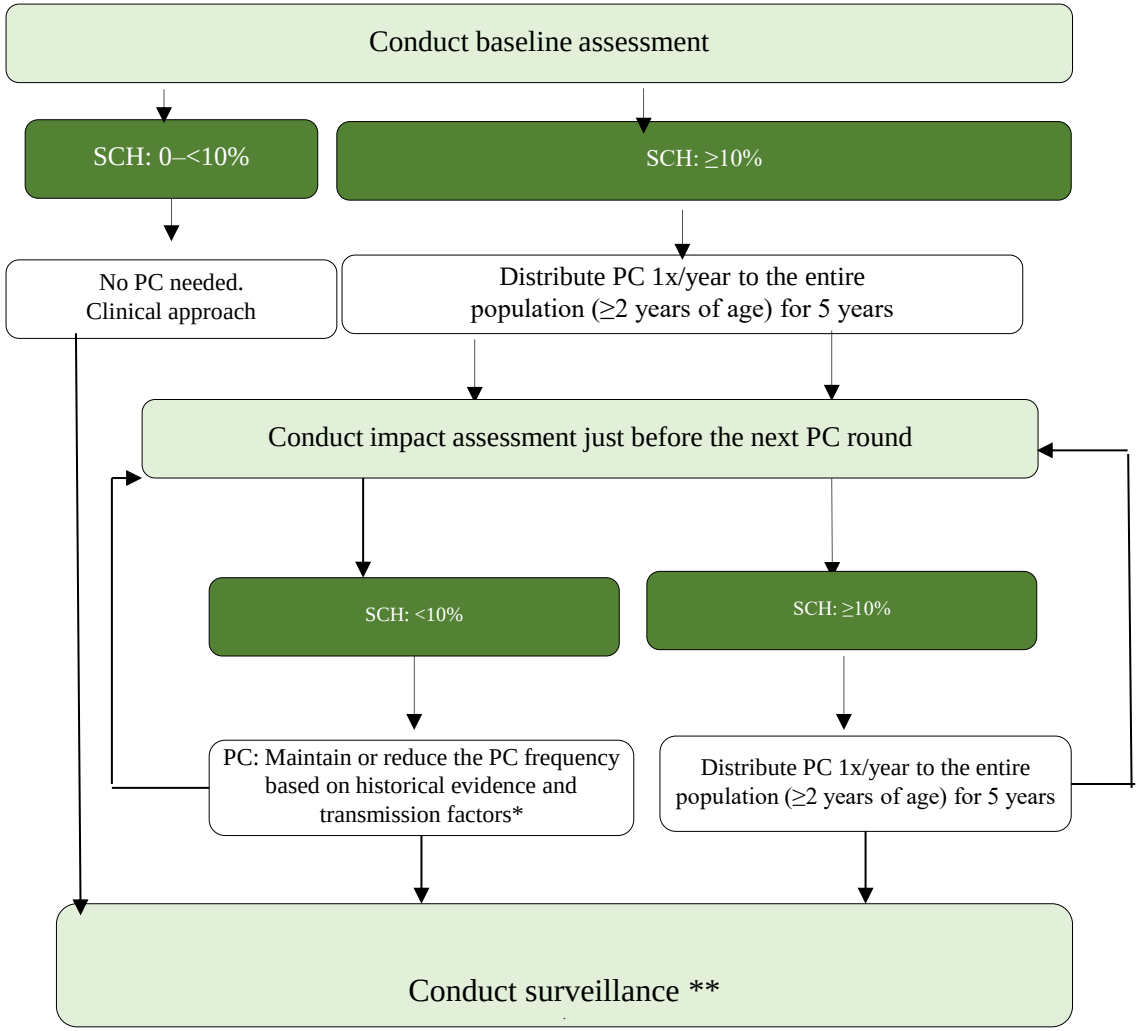
Method	Evaluation unit	Assumptions	Indication
Stratified sampling (with or without clusters)	Multiple IU in the same ecological zones Evaluation unit is the strata, prevalence is the average across IU within strata	STH/SCH epidemiology is uniform in each stratum of the area surveyed	Baseline surveys in settings where limited information is available on the epidemiology of the diseases
Cluster survey	IU (district, group of districts, ecological zone) Decision unit is the IU (district, group of districts, ecological zone) with a precise prevalence value determined for each	STH/SCH epidemiology is uniform in each IU	Baseline surveys for SCH and STH Could be used for impact assessments acknowledging an increased risk for under or over treatment because of heterogeneity
Lot quality assurance sampling	Multiple IU in the same ecological zones	STH/SCH epidemiology is uniform in each stratum of the area surveyed	May be suitable for determining where PC is required using a prevalence threshold. Would need adapting around an intensity threshold for use in validation of EPHP
Sentinel surveillance	Multiple IU in the same ecological zones	The changes in STH and SCH epidemiology occurring in sentinel sites are similar to the changes in the area the sentinels are representing	More suitable for routine program monitoring; may play a role in surveillance after reducing the PC frequency; and post-validation surveillance alongside other active surveillance activities. Gives an overall indication of changes in infection but does not account for spatial heterogeneity of infection Not appropriate for IU-level treatment decisions
Model-based geo-statistical sampling[9]	The method provides a prevalence surface across a country, region, down to IU and sub-IU dependent on how the survey has been designed.	Available information can be used to identify the more informative schools or communities in which to conduct the investigation	Can be used for baseline assessment determining where PC is needed and for impact assessment. There may be increased certainty around estimates where there is sufficient quality and quantity of baseline epidemiological and intervention data available. Georeferenced sampling frame is available (that is, the location of all villages/schools is known)
Practical assessment	IU (e.g. district) Decision unit: sub-IU	Appropriate for settings with sparse data or where historical data or environmental data and knowledge on local risk factors suggest the prevalence may be universally low or high (relative to the 10% threshold)	Can be used for baseline or impact assessments for SCH. Could also be used for STH where there is co-endemicity with SCH Intended for SCH decision-making around a 10% prevalence threshold
Precision assessment	Sub-IU (e.g. sub-district) Decision unit: sub-IU	Appropriate to use at the sub-district level in settings where the prevalence of SCH is expected to vary around the 10% threshold	Suitable for SCH baseline and impact assessments. Intended for SCH decision-making around a 10% prevalence threshold Could also be practical for integrated STH–SCH assessment Could be used for baseline if used within the SPPA framework.

Decision tree for frequency of PC distribution for STH and assessments

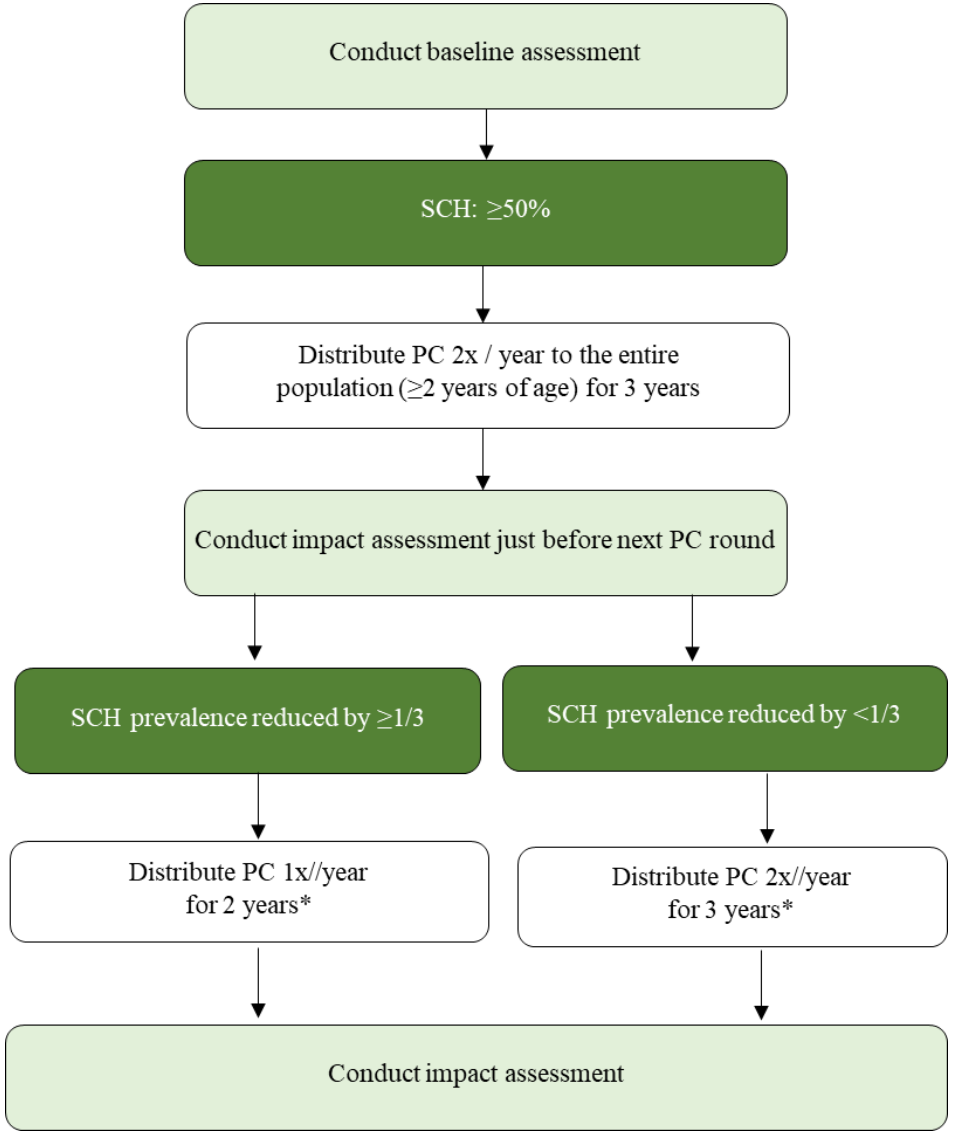


*** PC targeting entire age groups may be suspended, but distribution may continue in appropriate settings (e.g., selected child-health visits, selected school years, or at antenatal care visits)**

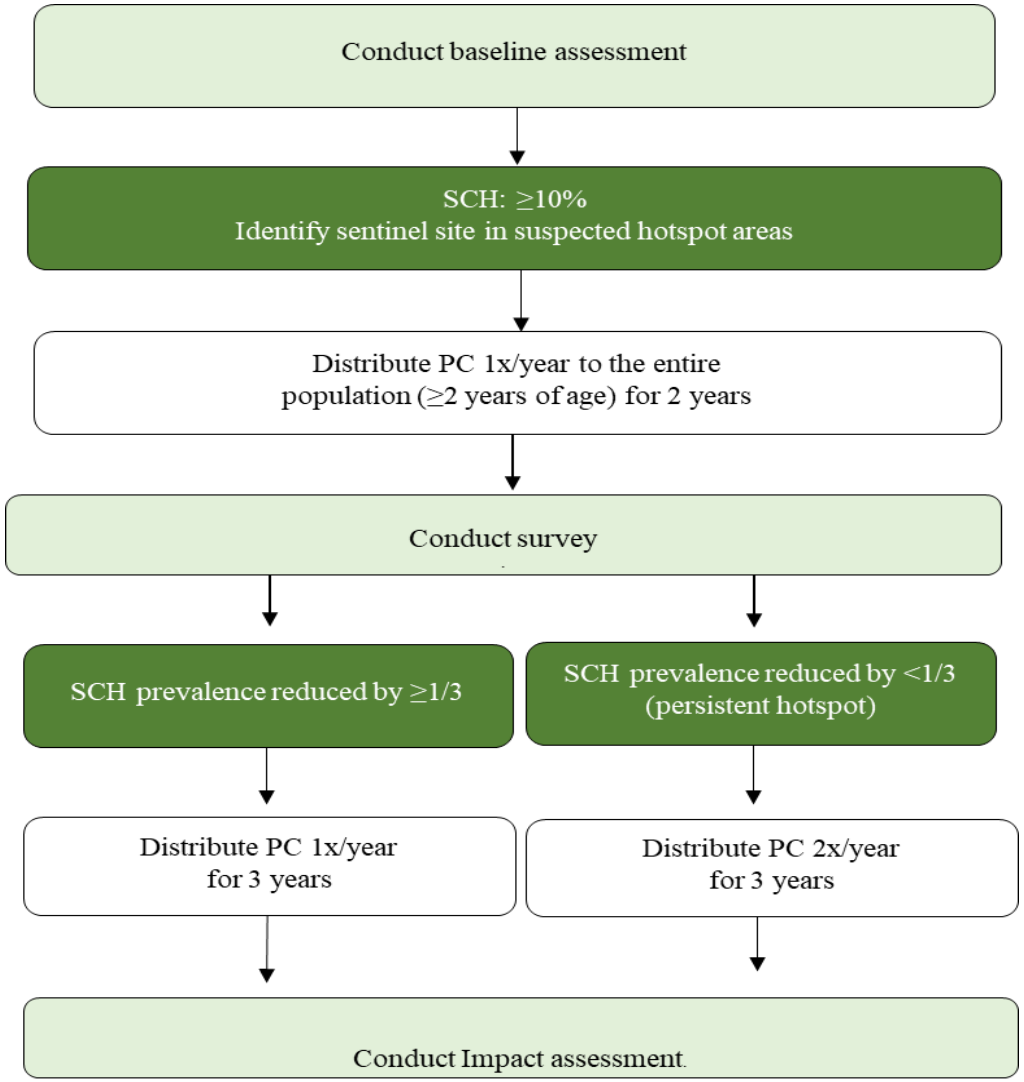
Standard approach for SCH



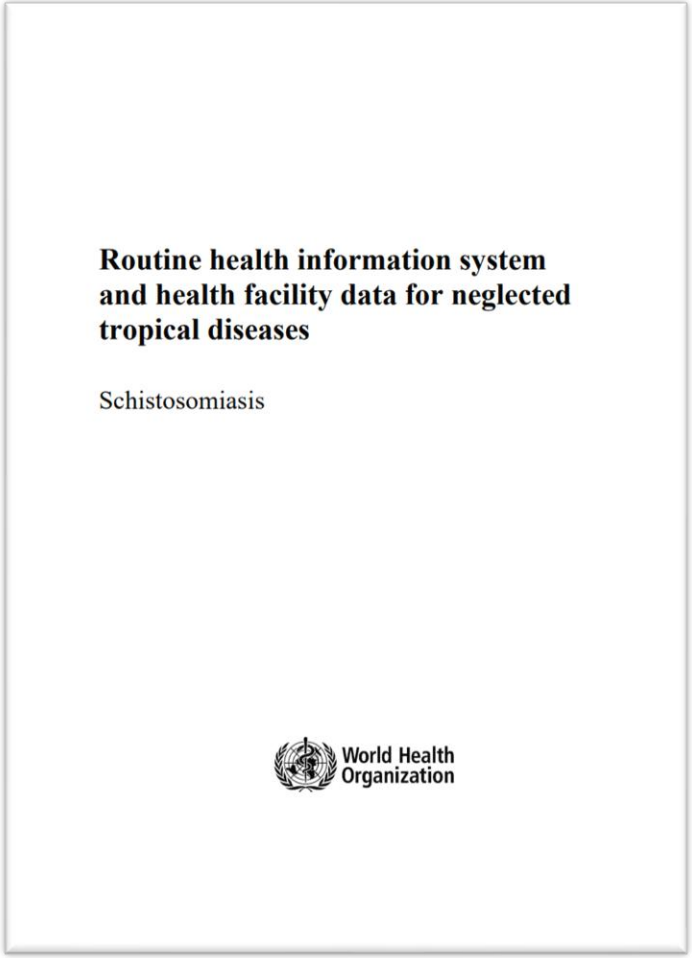
SCH Special case 1. High prevalence areas (P≥50%)

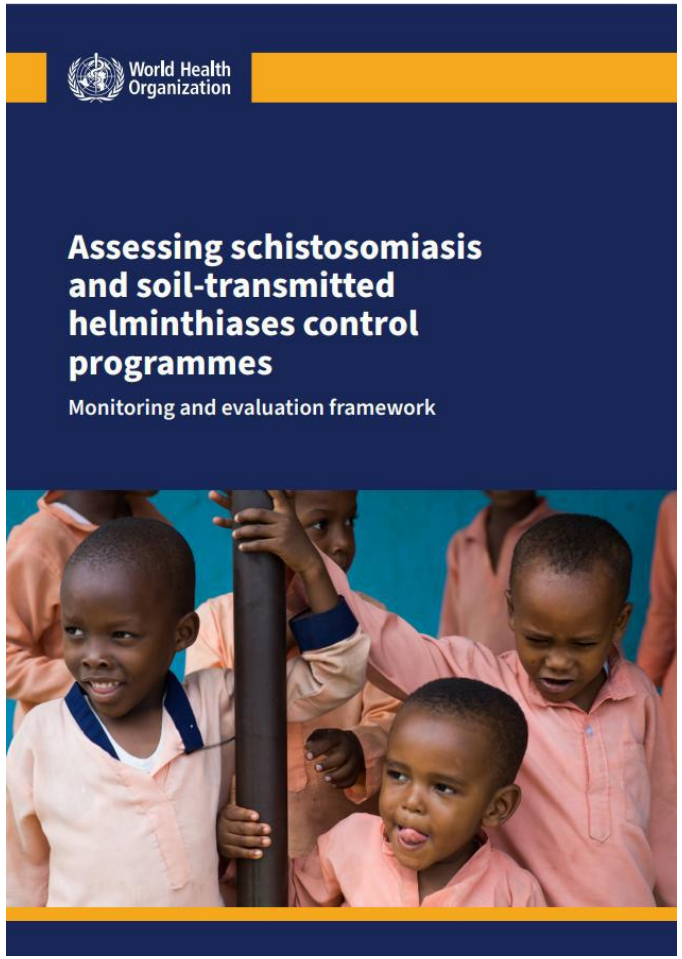


SCH Special case 2. Hot spots



Recent Publications on Monitoring and Evaluation

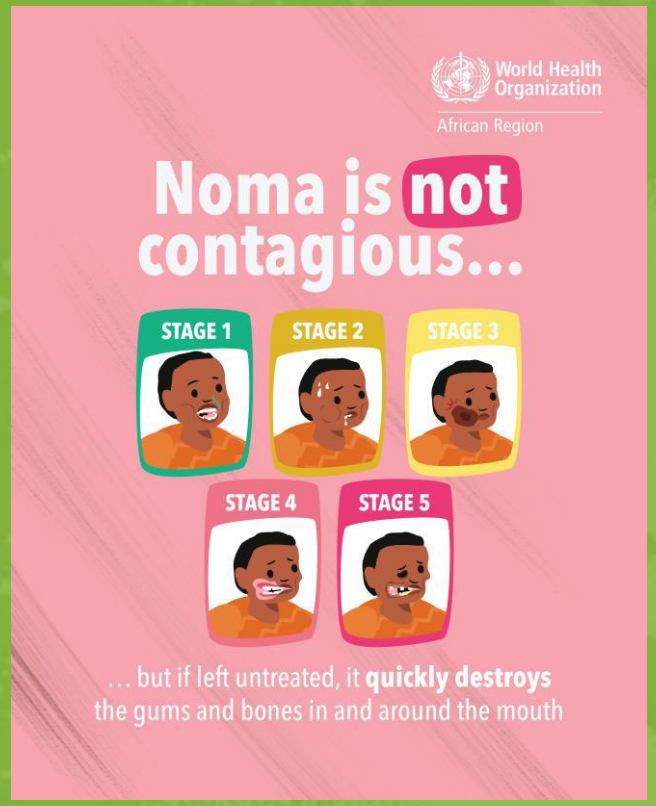




Thank you

World Health Organization

Session 15: noma



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ESPEN EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

Kuwait Fund For Arab Economic Development

THE END FUND ENDING NEGLECTED DISEASES

From recognition to action: positioning noma within the NTDs

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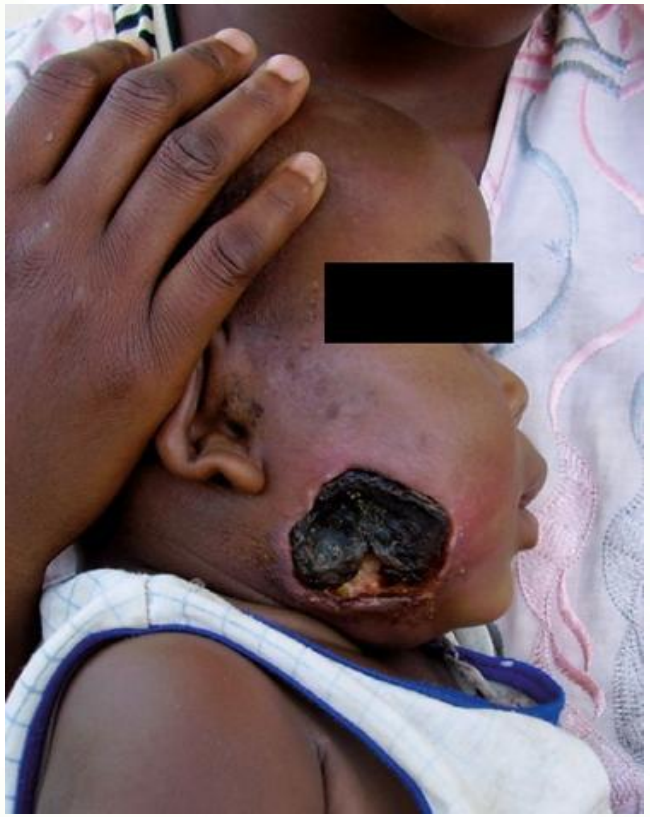
World Health Organization
African Region

ESPEN
EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

Annual Meeting of NTD National Programme Managers in the WHO African Region

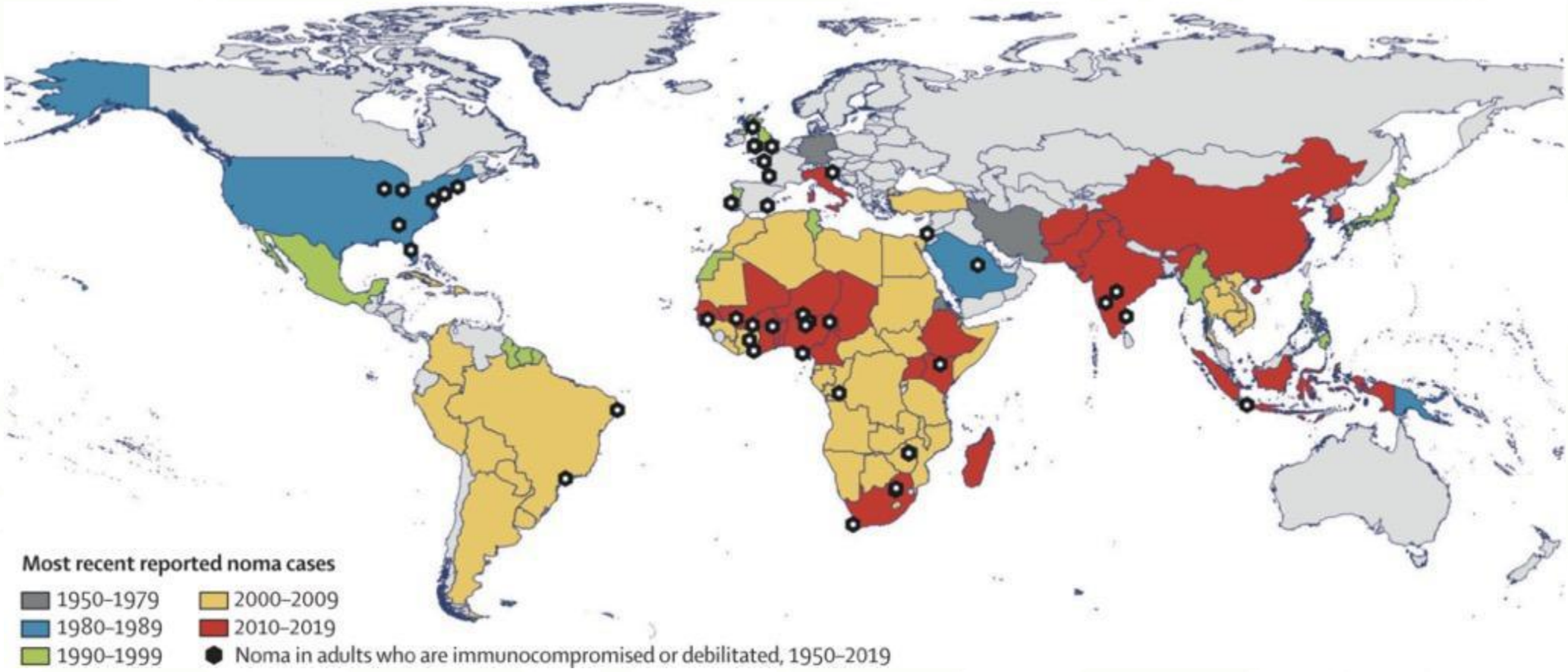
What is noma?

- **Noma** is a rapidly progressing, invasive, and debilitating oro-facial disease.
- It mainly affects children aged 2–6 years in the **most vulnerable** and **marginalized populations**.
- Its pathogenesis is linked to **non-specific polymicrobial organisms** of the oral cavity, opportunistically triggered by **malnutrition, poor oral hygiene, concomitant infections and other risk factors**.
- With **early detection** and **treatment**, its progression can be **rapidly halted**.
- Since December 2023, noma is the **latest NTD**.



Credit: Hilfsaktion Noma e.V.

Geographical distribution



Reference: Lancet Infect Dis. 2022 Mar 15, Galli A, Brugger C, Fürst T, Monnier N, Winkler MS, Steinmann P. Prevalence, incidence, and reported global distribution of noma: a systematic literature review. e221- e230

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Progress of activities since the inclusion of noma in the WHO NTDs list

01 Normative work facilitating inclusion into the WHO NTDs roadmap

02 Surveillance and data

03 Research

04 Tools

05 Country-level activities

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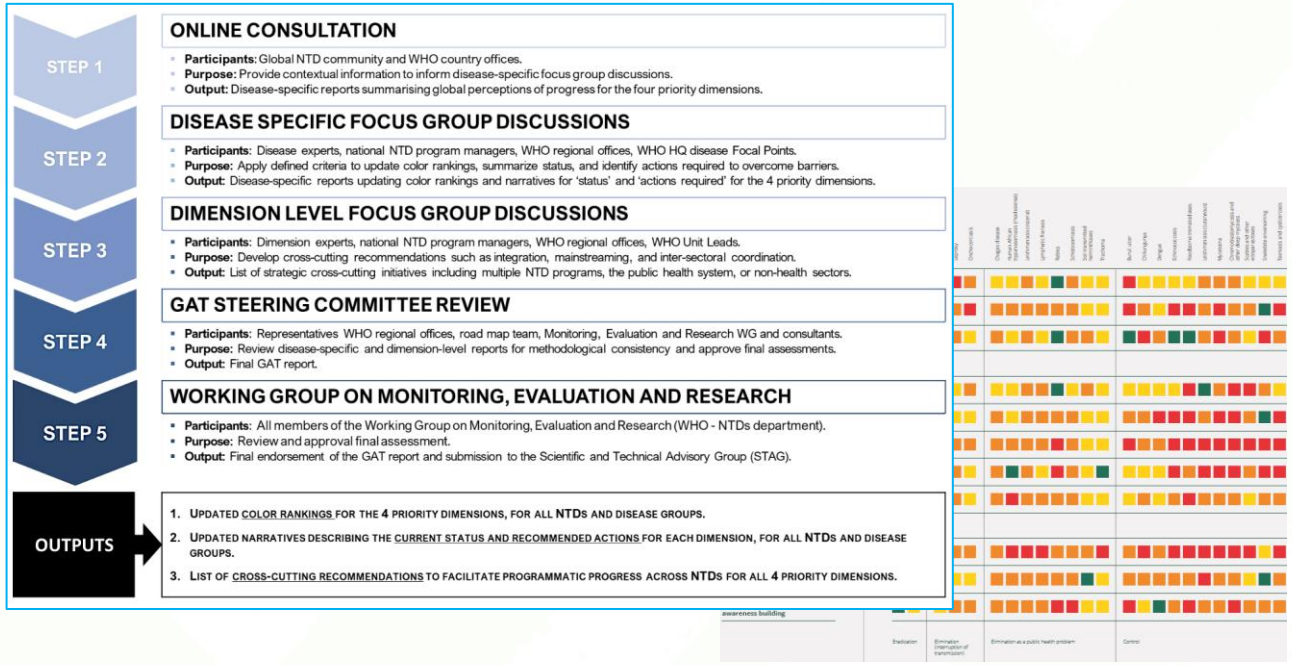
1: Normative work facilitating inclusion of noma in the NTD roadmap



Experts group meetings

Development of a disease summary for noma in line with those included in the road map 2021–2030

(endpoint target, indicators, core strategic interventions, burden of disease)

Work in progress

Gap Assessment Tool (GAT) exercise

(public consultation, focus group discussion)

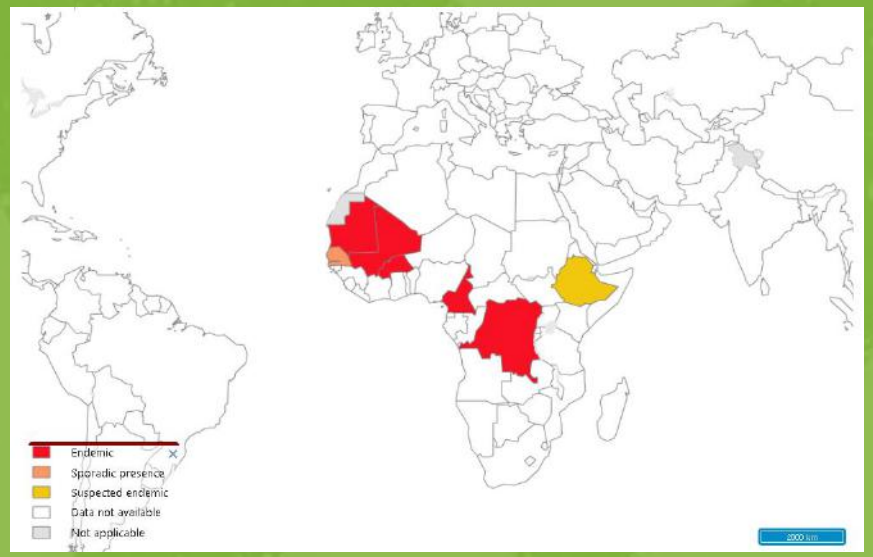
Qualitative assessment of programmatic status and identification of key areas requiring action

Completed for 4/11 dimensions

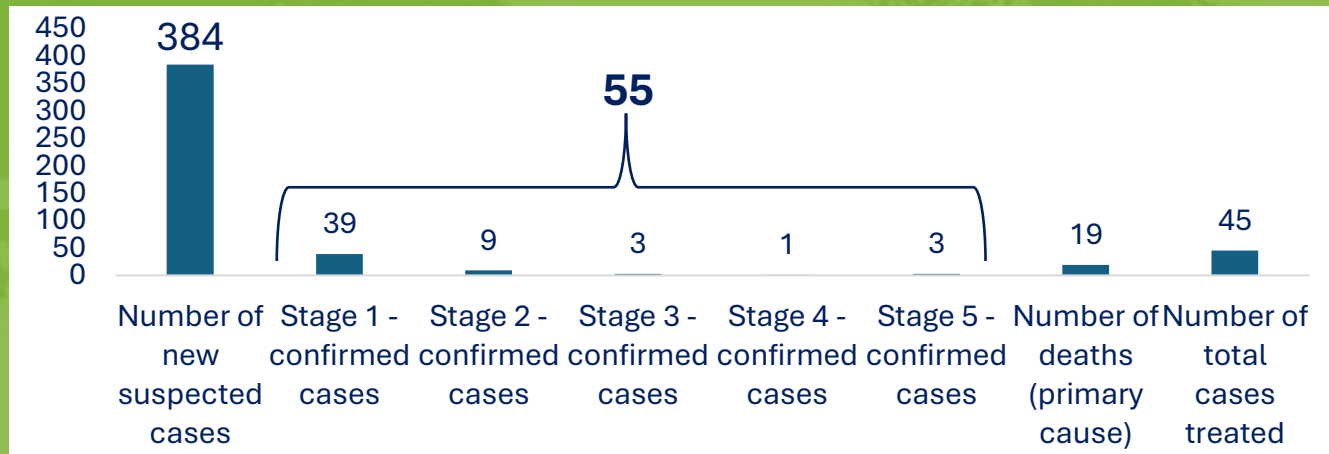
2: Surveillance and data

Inclusion of noma into the Global NTD Programme Annual Reporting Form (GNARF)

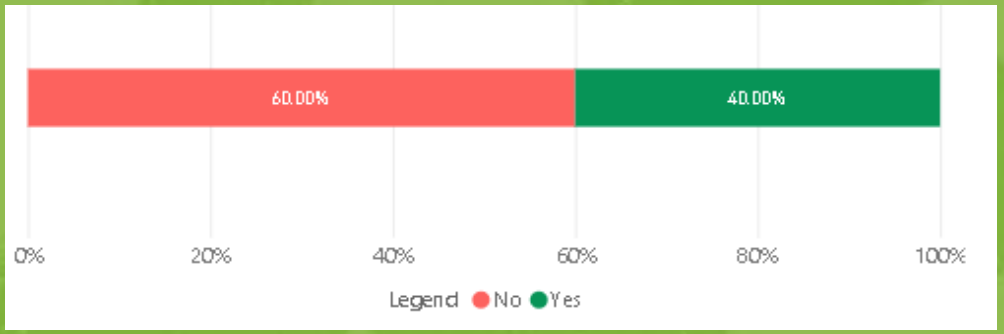
Countries reporting on endemicity status of noma, 2023 (n=7)



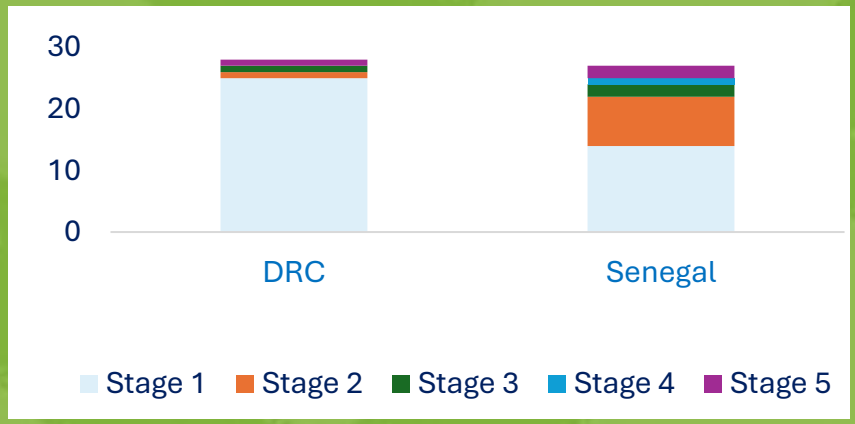
Reported cases of noma, 2023 (n=439, 4 countries: BFO, DRC, MAL, SEN)



Countries reporting on inclusion of noma into NTD action plans, 2023 (n=5) (Burkina Faso, Mauritania)



Clinically confirmed cases by country and stage, 2023



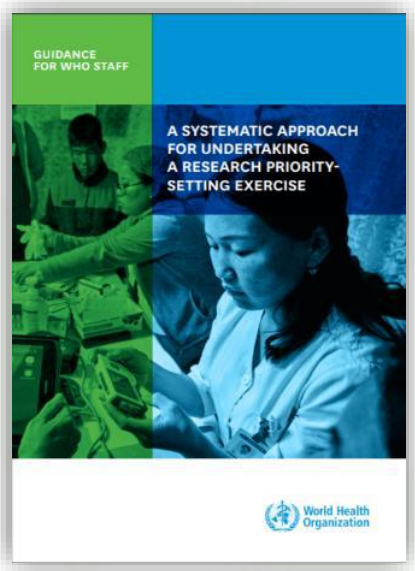
Deaths, 2023

DRC: 18
Senegal: 1

3: Research

Inclusion of noma in the WHO NTD R&D Blueprint

- Identify the R&D priorities that could lead to significant advances
- Broad-based consensus-building process
- Basic, clinical, social science and epidemiological research, including health product development and operational and implementation research
- Noma is part of the 21 disease- or disease-group-specific themes



Defining the noma research agenda

Swiss TPH Hybrid Symposium, 20 September 2024

- 100+ participants, including people living with noma
- Identification of 8 priorities
- Importance of integrated approach across sectors and disciplines

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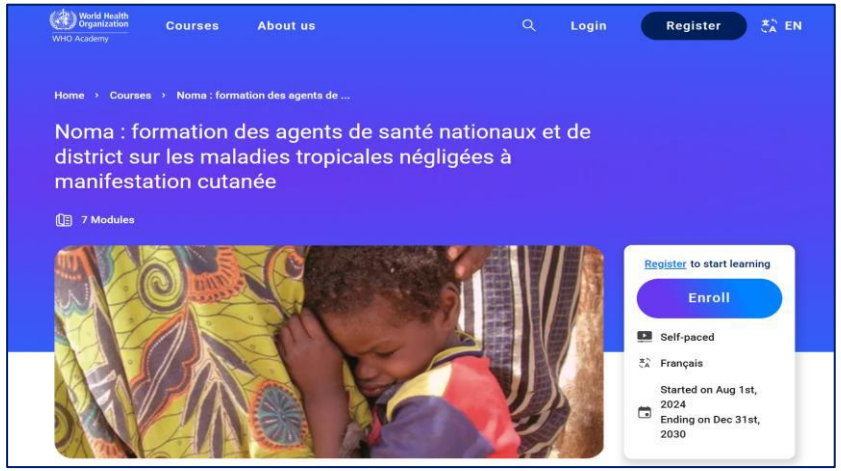
4: Tools

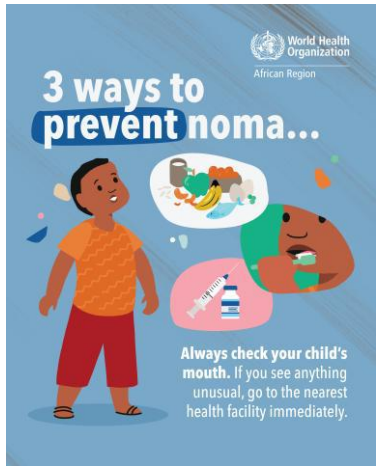
- **Online training course on noma available on the WHO Academy learning platform in 5 languages**
- **Information products for Oral Health Day 2025 (20 March 2025)**
  - Social media tiles on noma
  - Animation videos/Human stories video from Ethiopia
- **Mixed-media video on noma for policymakers** (to be released soon)
- **Community registry and case reporting template** (to be released soon)
- **Community health workers reference card/poster** (to be released soon)

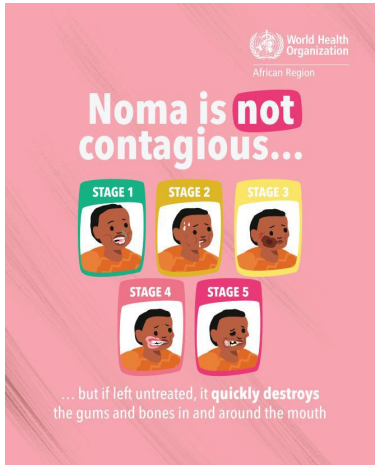
WHO Academy noma course

Oral health animation video

Noma animation video







5: Country-level activities

Benin, Senegal

- Training on GNARF
- Stakeholders meeting to foster collaboration between oral health and NTD programmes

Ethiopia

- Noma and SkinNTDs training for primary care and community extension workers (CEWs) in view of the inclusion of noma in the national NTD masterplan
- Active case detection of noma during MDA of IVM for onchocerciasis

Mozambique

- Support to resource mobilization plan for noma
- Aim at including noma into the national NTDs masterplan

A CEW asks a mother for the presence of a noma case in her family by showing pictures of noma patients while providing medicines for onchocerciasis
(Central Ethiopia Regional State, December 2024)

Human story video from Ethiopia

Next step

Inclusion of **noma control efforts** in **national NTD master plans**

Integration of noma into **surveillance systems** and **active case-detection** in high-endemic areas ***(Please support to submit national information through GNARF!)***

Expansion of **networks, partnerships** and **communities of practice** dedicated to noma (e.g., noma, NTDs, oral health, nutrition)

Communication and **advocacy strategy** to include **noma** in the **NTD brand** while maintaining the engagement of **oral health** community as well as other NCD actors and stakeholders

Capacity building of noma/oral health/NTD focal points and other professionals to prevent, detect, and treat noma

Resource mobilization to support countries in accelerating noma control efforts, including research

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THANK YOU

Please contact at:

makinoy@who.int

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Country experience on integrated approach for Noma control:

Active noma case-finding surveillance integrated with Onchocerciasis Mass Drug Administration in Ethiopia

Tesfahun Bishaw, NTD Manager, MOH

Dr Zeyede Kebede, NTDs Coordinator, WHO Ethiopia

Dr Henock Bekele, CM NTDs officer, WHO Ethiopia

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Background

Rapid Assessment was conducted in Nov 2022

- Identified 69 Noma cases treated from 2015-2020
- Confirmed that Noma is endemic in Ethiopia

National Noma Program was Launched

- July 2023 by the Ministry of Health
- In collaboration with AFRO, WCO Ethiopia, and Hilfsaktion Noma e.V.

National Noma Program Launching

Photo credit: WCO Ethiopia

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Program Implementation: 2023-2024

Capacity-Building Training:

- Primary Health Care Workers: **304** trained on Noma case finding and management using *OpenWHO* training materials
- Community HEWs: **626** trained on promoting oral health, Noma case finding, referral, and a reporting system
- A Telegram group consisting of trainees, trainers, and NTD officers created for discussion on Noma and skin NTDs and reporting Noma suspects

Integrated Active Surveillance: Instrumental for Noma case finding

Advocacy to include Noma in the next National NTDs strategic Plan (2026-2030)

National Noma Program Training

Photo credit: WCO Ethiopia

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Active Noma Case-finding Surveillance (ACS) integrated with Onchocerciasis Mass Drug Administration (MDA) in the Central Ethiopia Region (CER)

Integrated ACS: The WCO in collaboration with TCC, MoH, RHB, and DHOs conducted Noma ACS integrated with the Oncho MDA campaign in the CER

Objective:

- To identify, treat, and document undiagnosed noma cases in the community
- To determine the current burden of Noma in Ethiopia
- To devise an evidence-based strategy to be incorporated in the national NTDs strategic plan 2026 - 2030

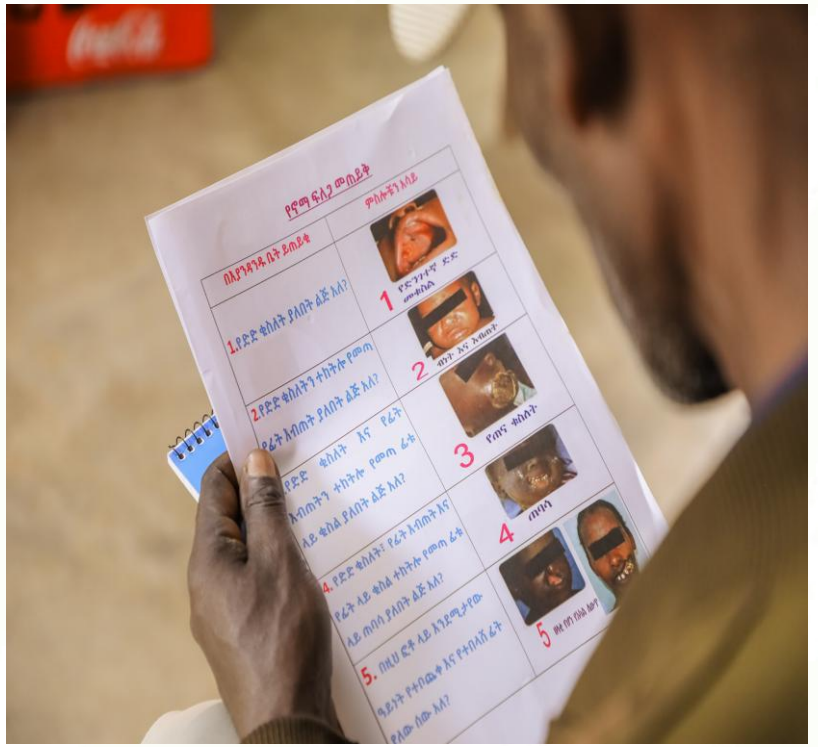

Photo credit: WCO Ethiopia

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Integrated approaches

Integrated capacity building training: on Noma ACS and Oncho MDA for 80 district NTD officers and primary healthcare workers who supervised the two campaigns simultaneously, supported by The Carter Center and Hilfsaktion Noma e.V

Integrated Orientation: on the Noma ACS and the Oncho MDA for 238 community health extension workers (CHEWs) who did a HH Noma case search using a checklist while providing Oncho MDA

Orientation of CHEWs on Noma ACS

Photo credit: WCO Ethiopia

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Integrated approaches ....

Simultaneous distribution of the Noma ACS and Oncho MDA activity checklists and reporting formats via district health offices

Printouts of Noma ACS checklists, case reporting formats, and IEC materials

Integrated Implementation of the Noma ACS and the Oncho MDA: The HEW asked the HH member for the presence of a Noma case by showing pictures of patients with the 5 stages of Noma while providing IVM for Oncho to each eligible individual

CHEW asks a mother for the presence of a noma

Photo credit: WCO Ethiopia

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Integrated approaches ....

Integrated Supportive Supervision was conducted by trained NTD officers and primary healthcare workers while CHEWs were doing the Noma ACS and the Oncho MDA

Integrated data compiling and reporting: The NTD officers collected, compiled, and reported the data of the Noma ACS activity and the Oncho MDA activity at the same time

CHEW asks a mother for the presence of a Noma

Photo credit: WCO Ethiopia

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Result

Early-stage Noma: The Noma ACS, done by integrating with the Oncho MDA in the CER, identified, treated, and documented 3 undiagnosed early-stage noma cases in the community

Coverage: The HEWs reached 1,213,544 individuals for doing the Noma ACS and providing Oncho MDA from the planned 1,231,241 people, with a coverage of 98.6%

Stage 2 Noma case found by ACS during MDA

Photo credit: WCO Ethiopia

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Result

Advanced stage Noma:
One stage 5 noma case with sequelae was identified during an integrated Mycetoma and skin NTDs case-finding campaign and linked to treatment

Stage 5 Noma case found during skin NTD ACS

Photo credit: Professor Wondimagegn Embiale

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Result

Human Story: The WHO comm department conducted video shooting and photography of the Noma ACS activity in the CER

The human story of a Noma Survivor, Identified and reported by trained HEW worker, was also included in the documentation

Noma survivor found during ACS and MDA

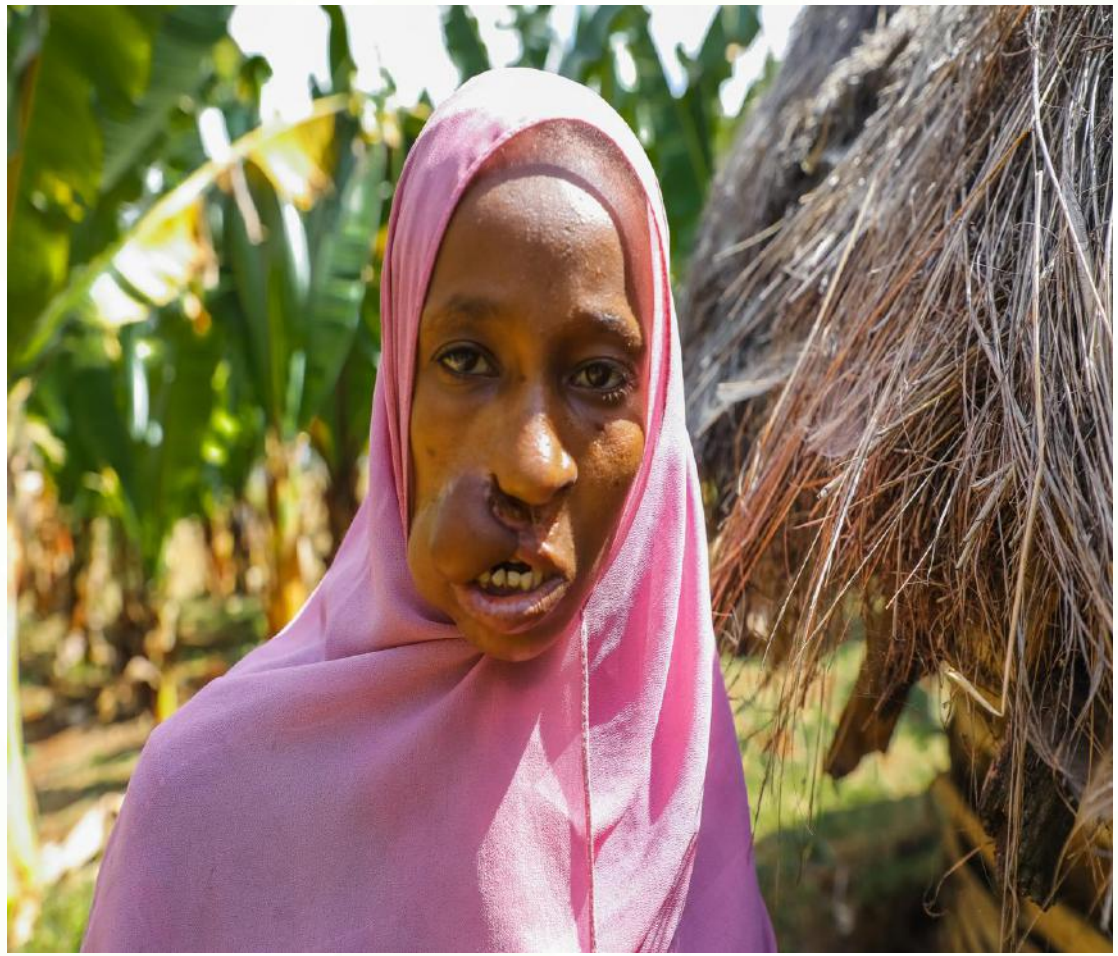

Photo credit: WCO Ethiopia

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Challenges

1. **Stigma and Discrimination:** Noma cases are often hidden in the community due to stigma and discrimination, making it difficult to identify and report these cases
2. **Data Collection:** Noma program indicators are not included in the national DHIS2 reporting system. A community reporting form distributed, but no regular reporting
3. **Hard-to-Reach Communities:** Detecting cases in remote or hard-to-reach areas is challenging due to logistical issues and limited access to healthcare services
4. **Limited Awareness**: Lack of awareness about Noma among both healthcare providers and the general population can lead to underreporting and misdiagnosis.
5. **Resource Constraints:** Limited government resources for training, surveillance, and treatment

Way Forward

- ✓ **Inclusion of Noma in the NTD Strategic Plan : (2026 – 2030)**
- ✓ **DHIS2 Reporting System: Including Noma program indicators**
- ✓ **Training: Continue capacity-building at primary health care and community level**
- ✓ **Surveillance: Continue active surveillance for Noma by integrating with different health campaigns**
- ✓ **Noma and oral health Indicators Catalog: To be produced for health facilities**

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Acknowledgement

Hilfsaktion Noma e.V.

AFRO

MoH of Ethiopia

Video Link: WHO_Noma_EN.mp4

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Lunch Break

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Partners Updates and Remarks

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Contribution of DNDi in the control and elimination of NTDs

The Best Science for the Most Neglected

Prof Sam Kariuki, Africa Continental Lead - DNDi

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LEISHMANIASIS

ADVANCING A PORTFOLIO OF ALL-NEW ORAL DRUGS, FOR PEOPLE OF ALL AGES

FACTS

600 million
people at risk of visceral leishmaniasis across the globe

600,000-1million
new cases of CL each year

At least 100x
greater risk of developing active VL for people living with HIV

15 YEARS AGO

Toxic, painful, resistant, not registered, expensive, lengthy, not field-adapted treatments.

2010

DNDi introduces SSG & Paromomycin for Visceral Leishmaniasis in Africa

2014

New treatments for Visceral Leishmaniasis were introduced in Asia

2022

- New Ambisome / Miltefosine **combination for HIV/VL treatment**
- New treatment for VL in Latin America

From 2025

- New Miltefosine / Paromomycin combination **for VL treatment**
- New Paromomycin/ Miltefosine **combination for PKDL treatment in Africa**

Radically improved, all oral treatments, with new chemical entities

DNDi

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DELIVERING BREAKTHROUGH TREATMENTS AND EXPEDITING ACCESS FOR SUSTAINED ELIMINATION

15 YEARS AGO ▶ **2009** ▶ **2018** ▶ **2023** ▶

MELARSOPROL

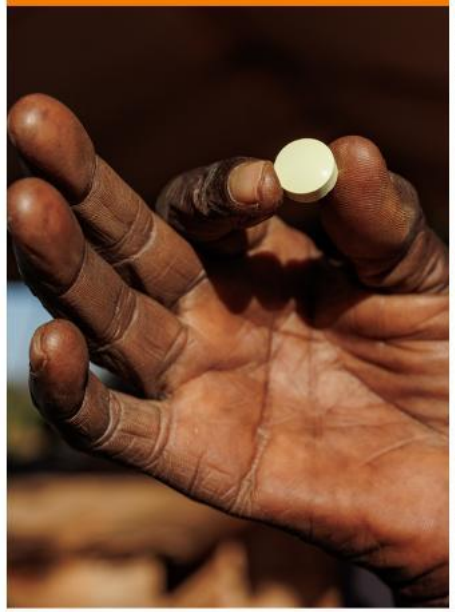
'Fire in the veins'

NECT

Effective and safe but hospital-based and complex logistics.

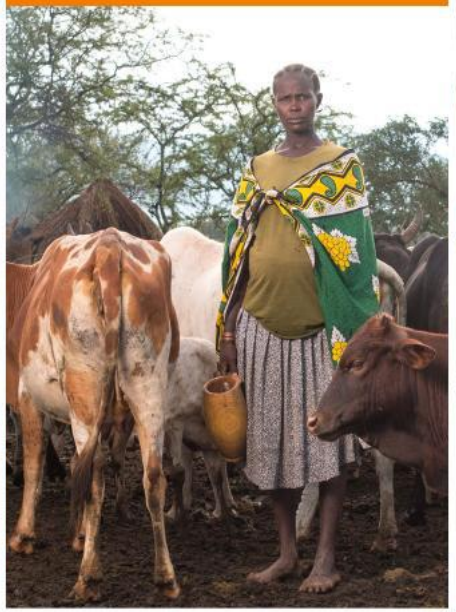
FEXINIDAZOLE

All-oral. Once a day for 10 days for *T.b. gambiense.*



FEXINIDAZOLE for r-HAT

EMA positive opinion Dec 2023



ACOZIBOROLE

An innovative single-dose oral treatment to sustain elimination

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FILARIA: RIVER BLINDNESS

Aligning with the new WHO roadmap and developing a macrofilaricide

31 COUNTRIES
Onchocerciasis, or river blindness, is endemic in 31 African countries. Over 21 million people are infected.

Over
17 MILLION
people infected

About
198 MILLION
people at risk

NOW

- Mass Drug Administration (MDA, ivermectin)
- **Ivermectin does not kill the adult worms**
- Sustainable Development Goals cannot be met with current tools

2020

3 drug candidates in development for river blindness:

- Emodepside
- TylAMac®
- Oxfendazole

abbvie Bayer HealthCare

FUTURE

A safe, effective, affordable, and field-adapted drug that can kill adult filarial worms (a 'macrofilaricide') and be used for prevention or individual treatment.

MYCETOMA

Looking for effective treatments

Disease burden is concentrated in the 'mycetoma belt' (between latitudes 15° S and 30° N)

Global burden is unknown

1ST DNDi and the Mycetoma Research Centre in Khartoum, Sudan are conducting the world's first mycetoma clinical trial

Until today

Ketoconazole and itraconazole to treat fungal form is a 12-month long treatment with Serious side effects, only 25-35% effective and unaffordable

May 2016

Mycetoma added to WHO NTD list. More visibility for funding and research programmes

By 2023-2025

Fosravuconazole: a more effective, affordable, shorter-term treatment appropriate for rural settings

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END Fund

Collaborative Partnerships and Multi-Stakeholder Engagement

Kendra Palmer

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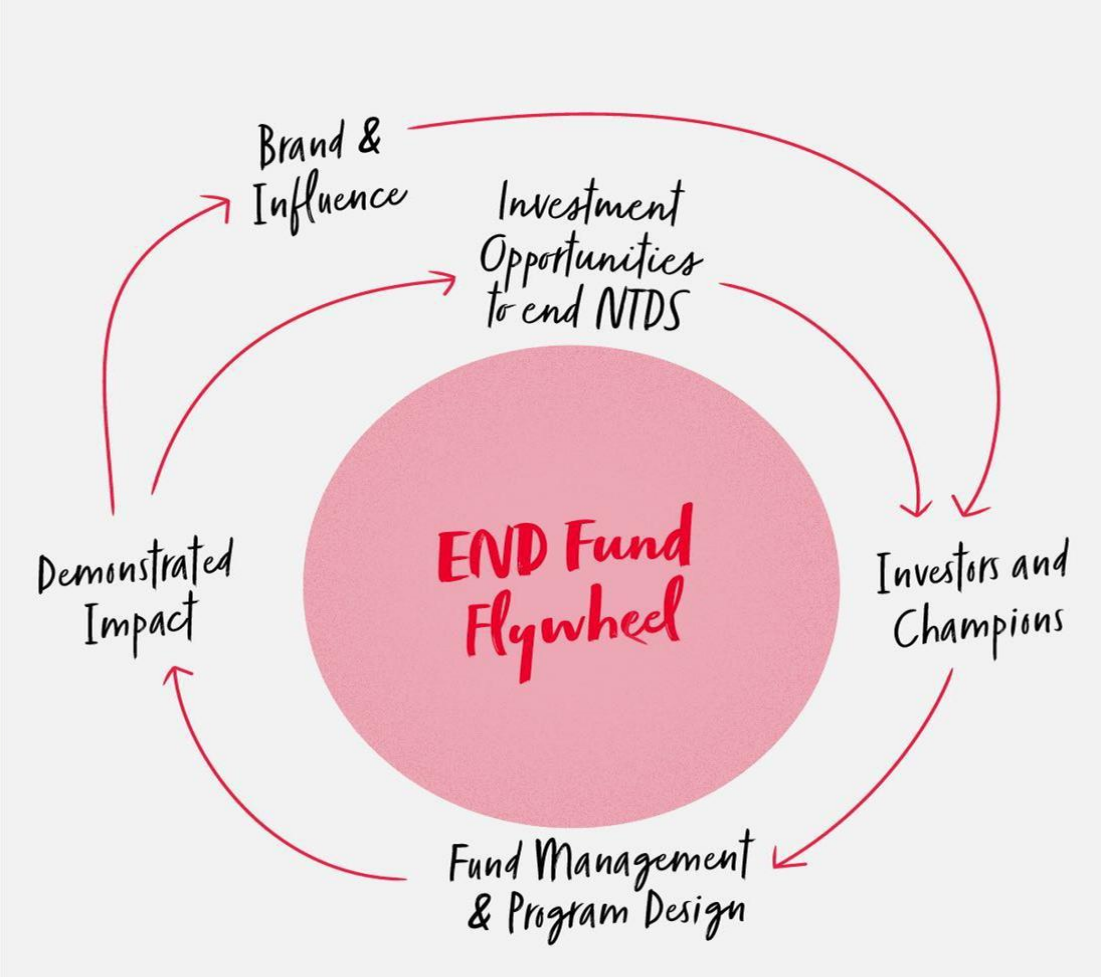
The END Fund exists to ensure people at risk of NTDs can live healthy and prosperous lives

2030 Vision: Enable 500 million people to live free of the burden of NTDs



Investment Funds:

- Flagship Fund
- REACHING the LAST MILE FUND
- Deworming Innovation Fund
- ARISE Fund

Core Functions:

- **Mobilize private philanthropic funding for NTDs**
- **Deploy funding in alignment with country-led NTD priorities**
- **Amplify and support disease endemic country leadership for NTD programs**
- **Support the NTD sector through advocacy, story-telling, thought leadership, convenings**

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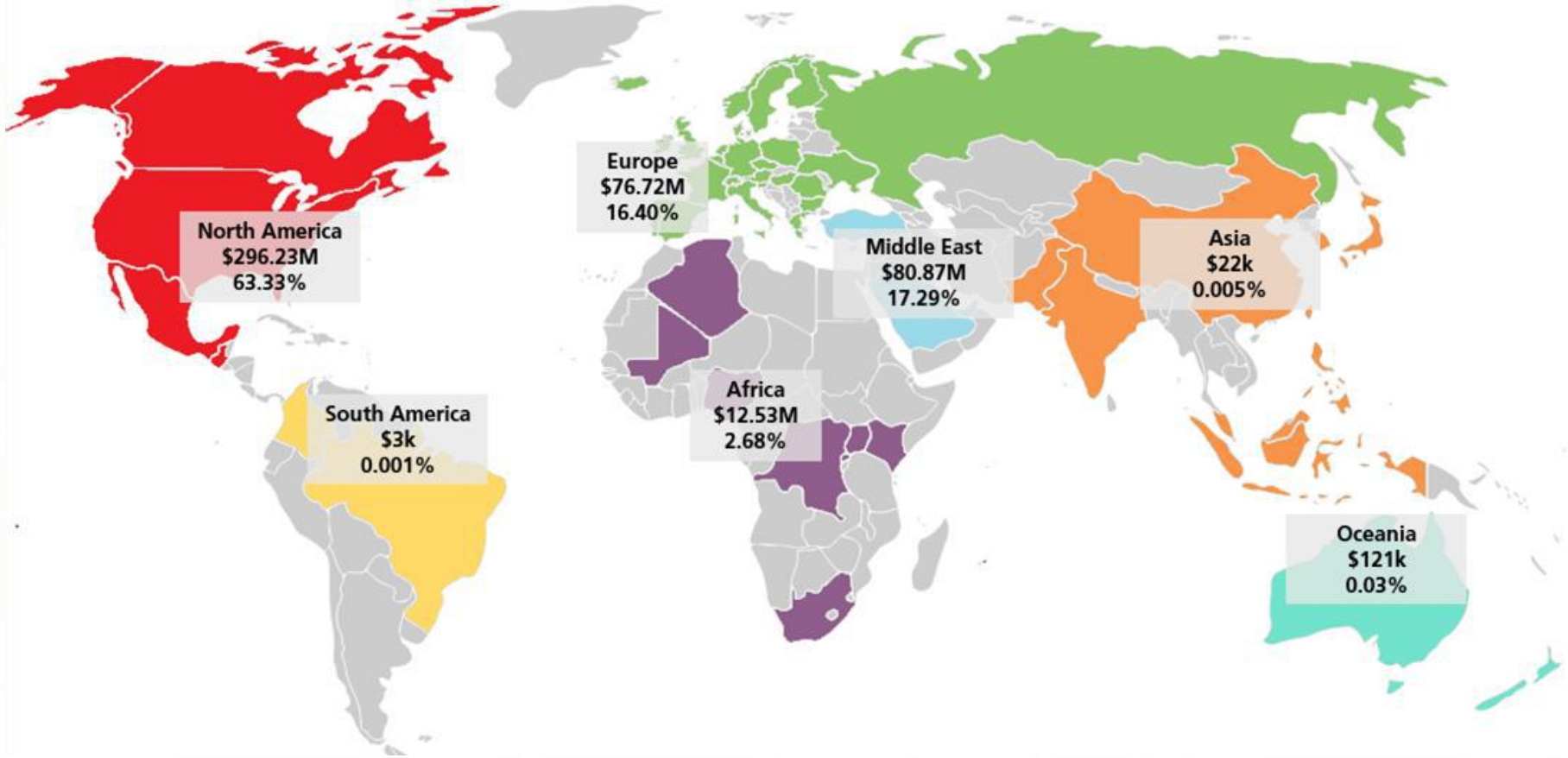
END Fund's primary mandate is to **mobilize and reinvest resources** from diverse investors for NTDs

$498 million in resources mobilized since 2012 from global funders

(Does not include the RLMF 2.0 commitments)



Over **6,400** unique investors from **63** countries

Primary sources:

- Foundations
- Individuals
- Corporate

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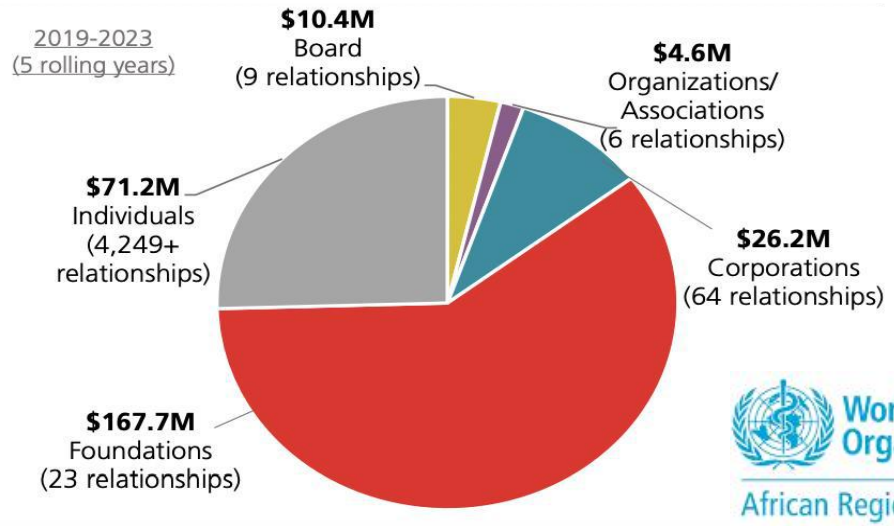
Resource mobilization priorities center on growth, diversification, and a captivating investor experience

Mobilize another $500M for NTDs by 2030 (Goal: $1B raised 2012-2030)

Steward investors with excellence and elegance to maintain and grow current and new investments

Serve as an **entry point** for new philanthropic investors to NTDs

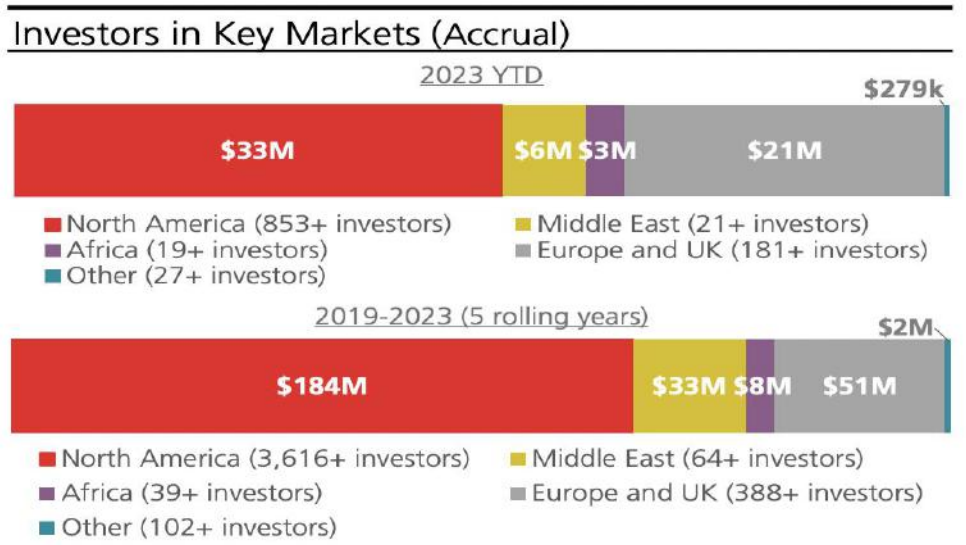
Expand corporate and institutional revenue; identify new individual investor acquisition channels



Leverage the power of **collaborative philanthropy** to fund programs at scale

Provide an **investor experience** that is inclusive, high-touch, participatory, collaborative, and impact and learnings driven

Expand markets (Africa, Europe, Middle East)



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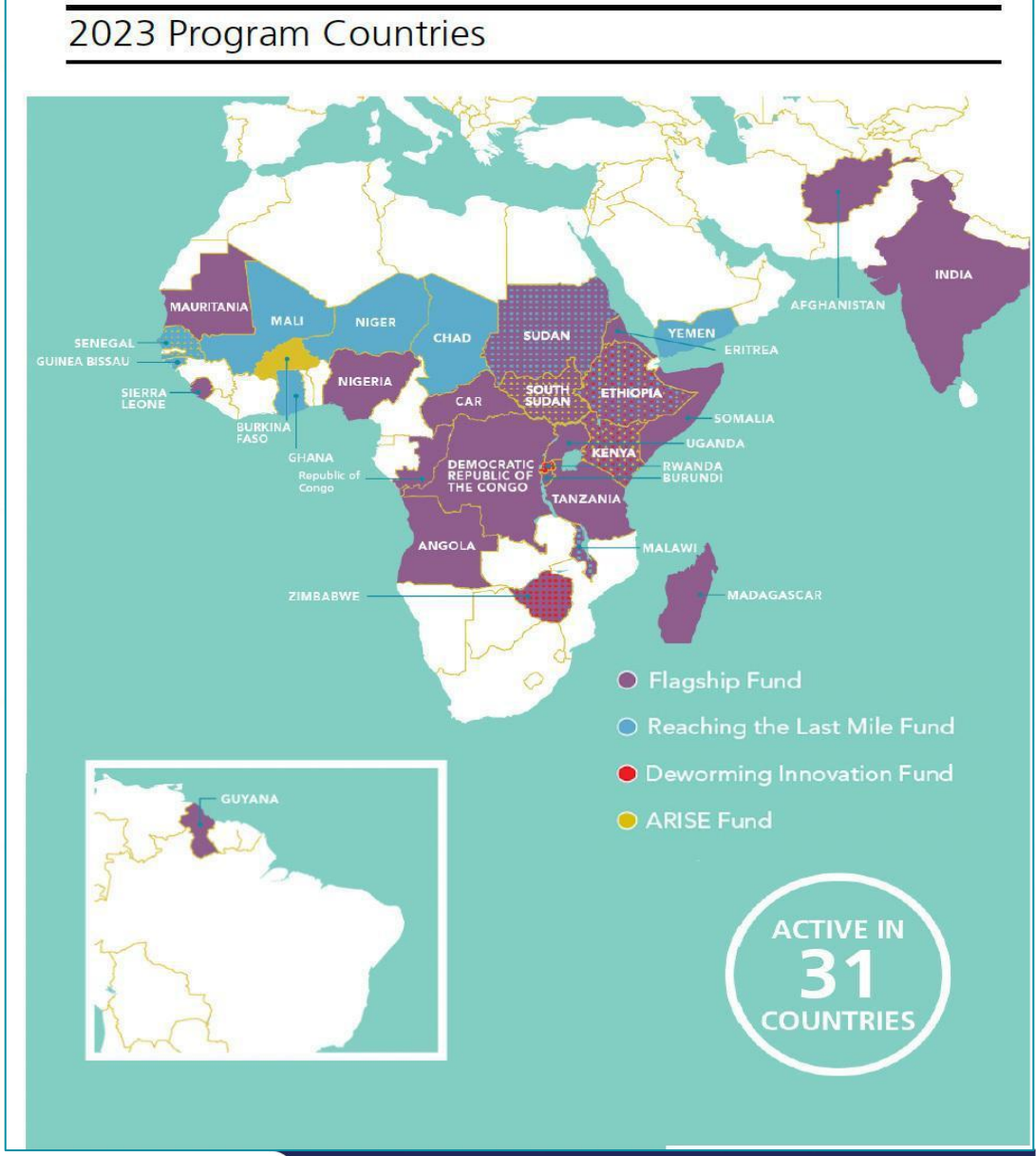
Our Footprint: END Fund supports primarily in Africa and the Middle East, with programs also in Guyana

Guiding Principles

- Country-led approach
- Long-standing government partnerships
- Support for progressive elimination opportunities and policies



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UNITING TO COMBAT
NEGLECTED TROPICAL DISEASES

Financing, Integration & Health Systems Strengthening

Ope Alabi-Hundeyin

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About Uniting to Combat NTDs

- Uniting is a global advocacy organisation dedicated to ending neglected tropical diseases.
- We mobilise resources in support of the World Health Organization's NTD roadmap and the target 3.3.
- We work with over 150 partners to build the political will and champion investment to control and eliminate NTDs.
- Navigating current funding landscape and foreign assistance cuts - Uniting is continuing to advocate and engage with existing and new donors, multilateral and regional banks, pharmaceuticals and the private sector to mobilise resources for NTDs.

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Sustainable financing

- Current funding landscape - external financing is threatened by cuts to official development assistance, with projections of more cuts in due to a volatile global economic landscape

- Countries must demonstrate ownership through increased domestic resource mobilisation and allocation to NTD programmes and embrace innovative approaches to financing including integration.

- Domestic resource mobilisation contributes significantly to building resilient health systems and remains a major requirement to complement external financing sources.

Innovative financing

Integration

- Integrating NTD interventions into broader health programmes and other sectors e.g. integrating FGS services within PHC, combining MDA for multiple NTDs, aligning NTD interventions and asks within existing health programmes and campaigns, and sectors such as nutrition, education, WASH etc.

- Integration improves efficiency, reduces costs and provides a viable pathway towards achieving UHC. UHC cannot be achieved without strong, resilient systems in place to promote health, especially at the grassroot level.

- Increase access to innovative funding for NTDs, for example access funding from the World Bank's IDA21 allocations for countries to implement disease elimination initiatives which will include NTD elimination.

Innovative financing

Innovative approaches include:

- Incorporate coverage for treatment of NTDs into country's national social health insurance schemes.
- Private sector funding and private sector foundations.
- Public private partnerships.
- Interministerial coordination - strong coordination between the Ministries of Heath and Finance to access funding for NTDs. For example, access funding for NTDs under disease elimination lens for IDA21.
- Regional financing – AfDB regional financing window and the World Bank regional window.
- Debt for health swap

IF WE ARE TO MEET THE SDG AND WHO NTD Roadmap TARGETS

IF WE ARE TO SAFEGUARD THE HARD-WON ELIMINATION GAINS OF THE PAST DECADE

We need strong political will and country ownership and an increase in sustained domestic resource allocation to NTDs.

We need countries to demonstrate political will through the endorsement of the Kigali Declaration on NTDs

We need to explore innovative ways of unlocking domestic and international financing mechanisms to eliminate diseases on the continent.

Let us UNITE ACT ELIMINATE NTDs in Africa!

World Health Organization
African Region

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THANK YOU

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Annual Meeting of NTD National Programme Managers in the WHO African Region

Closing Remarks

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EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

Annual Meeting of NTD National Programme Managers in the WHO African Region

Evaluation Survey: Annual NTD Programme Managers' Meeting 2025

15-17 April 2025 Lomé, Togo.

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Thank You
Merci Beaucoup
Obrigado Barak

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