



TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING
NTD Data Use, Reporting and Supply Chain
Capacity

Kintélé, Brazzaville,
Republic of the Congo

DAY 1



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



Training workshop on effective PC-NTDs data processing and use

Kintélé, Brazzaville,
Republic of the Congo
August 24, 2026 | 9 Countries.

Objectives, Expected Outputs and Agenda

Obo Junholv, Data analyst





Why this workshop

The gap is not the platform. It is the routine and the people.

74%

have a fully operational
national DHIS2 platform

32%

use NTD data for decisions
at health-facility level

59%

have no data analyst,
biostatistician or
GIS specialist

The systems are built. The skills and the routines to use them are not.

Our objective for the week

Strengthen national capacity to process, report, analyse and use PC-NTD data
so that programmes can plan better, forecast better, and reach the people who need treatment

1

Data quality

Standard cleaning,
validation and QA

2

Reporting

JAP, JRF, GNARF
submitted on time

3

Forecasting

Medicine needs
2027 – 2030

4

Digital tools

ESPEN Portal, Collect,
AI assistant



What you should leave with on Friday

Five outputs, per country

- 1 JRF 2025 finalised and submitted through the JAP upload tool
- 2 JRSM 2027 prepared, validated and submitted
- 3 IU-level demographic projections for 2027 – 2030
- 4 A country action plan with dated post-workshop milestones
- 5 Practical use of the ESPEN Portal and the AI assistant



The week at a glance

Mon 24	Tue 25	Wed 26	Thu 27	Fri 28
Foundations	Disease tools	JAP reporting	Forecasting	Finalisation
Indicators and definitions	SCH Community Workbook	JRF 2025 step by step	GNARF requirements	ESPEN Collect and HMIS
Data quality assurance	JRSM 2027 hands-on	AI technical review	Medicine needs 2027–30	Submission of files
ESPEN digital ecosystem	AI-assisted review	Country group work	Supply chain decisions	Country action plans

Each day: plenary 08:00 – 17:00, one country moderator and one WHO moderator, two rapporteurs



How we will work

Less presenting, more doing

Hands-on

Guided exercises on your own country data
not on examples

Country teams

You work as a national team, with a facilitator
on call

Peer exchange

Each country presents what it found
and how it resolved it

AI-assisted

The ESPEN assistant flags inconsistencies, you
decide what to do

A daily report is produced from the session recording and shared with presenters for review.



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What we will check afterwards

The workshop is judged on what happens after it

1 month	3 months	6 months
100% updated IU-level demographic projections 2027–2030	80% technically validated JRSM 2027	100% technically validated JRSM 2027
100% technically validated JRF 2025 using version 4	100% used the JAP upload tool	100% submitted GNARF 2025

These are the indicators ESPEN will report on. They are country commitments, agreed here.

Three things for this week

1

Bring your files out
Every session works on
your own country data

2

Ask while we are here
Facilitators are available all week,
not only in plenary

3

Leave with it finished
Submitted files, not a list of
things to do at home

•**THANK**
•**YOU**



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TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING NTD Data Use, Reporting and Supply Chain Capacity

Kintélé, Brazzaville,
Republic of the Congo

Country Assessment Survey ·

34 countries · July–August 2026

Findings, lessons and priorities for action

Honorat Zouré, Database administrator
Obo Junholv, Data analyst



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What we did — and whether the data will bear it

34

countries, one submission each

23 of 34

answered by the programme manager, not a data specialist

73 of 74

question fields have no missing values

What to keep in mind

- Self-reported perception, not independent measurement
- One respondent per country — judgement is not averaged out
- Staffing counts (G.5) are not comparable across countries
- 34 of the Region's countries responded; Chad is absent

Remember

“There is nothing either good or bad, but thinking makes it so.”

—William Shakespeare, Hamlet, Act 2, Scene 2

One country is 3 percentage points. Read every figure with a margin of about one country, and treat differences under ten points as noise.

The survey in eight numbers

34 countries · ESPEN NTD Country Assessment Survey · July–August 2026

74%

have a fully operational national DHIS2 platform (B.1)

79%

still collect NTD data on paper first (C.2)

32%

use NTD data for decisions at health-facility level (C.1)

59%

have no data analyst, biostatistician or GIS specialist (G.5)

62%

have electronic stock tracking, fully or partly (F.1)

74%

cite delayed reporting as a supply chain challenge (F.5)

71%

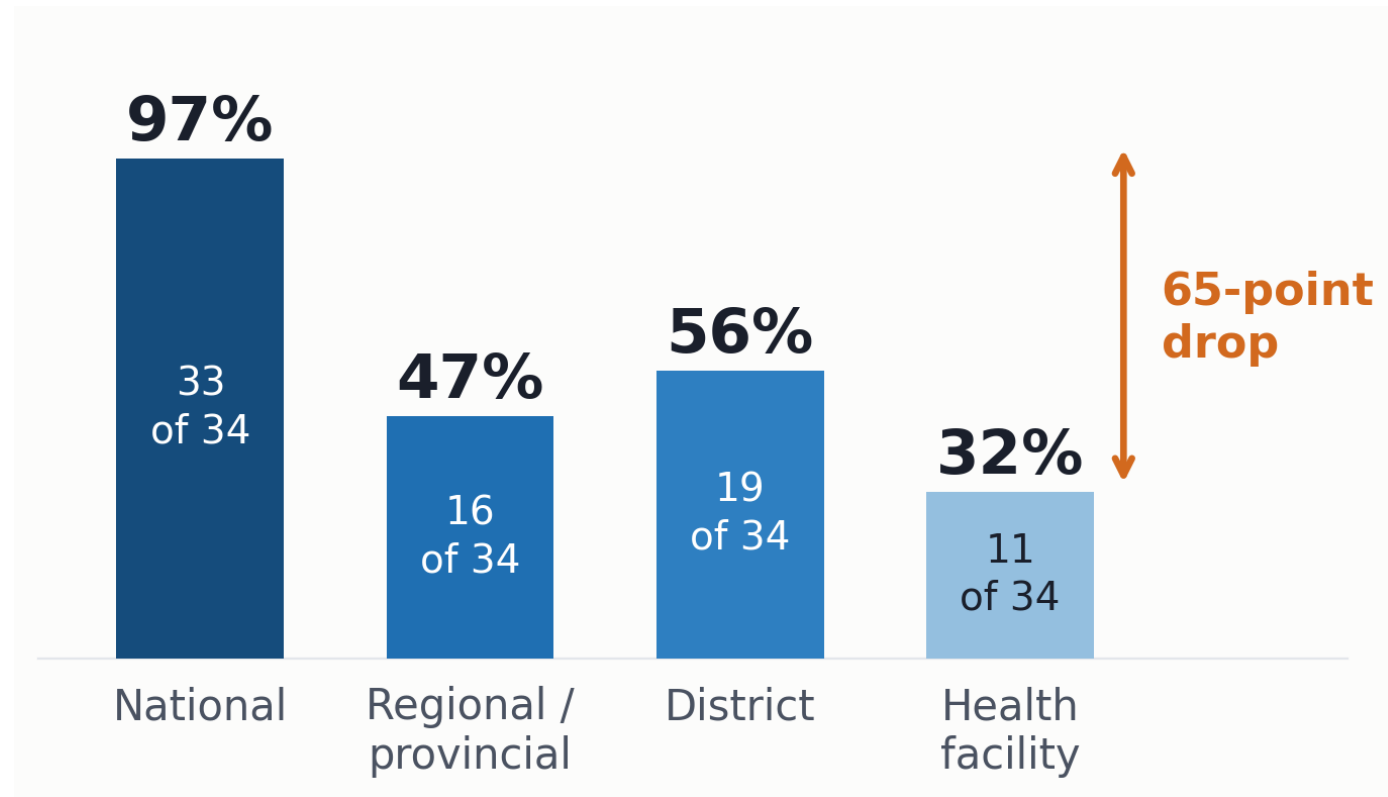
rate their team's AI skill as "none" or "basic" (H.14)

96%

of ESPEN workshop attendees improved JRSM preparation (J.4)

The platform is built — but the data stops at the top

Objective 1 · DHIS2 platform (B.1–B.3) and where NTD data informs decisions (C.1)



The people who collect the data are the least likely to see it used.

33 of 34

have an operational DHIS2 platform — median 11 years old

12 countries

use NTD data at national level only

4 countries

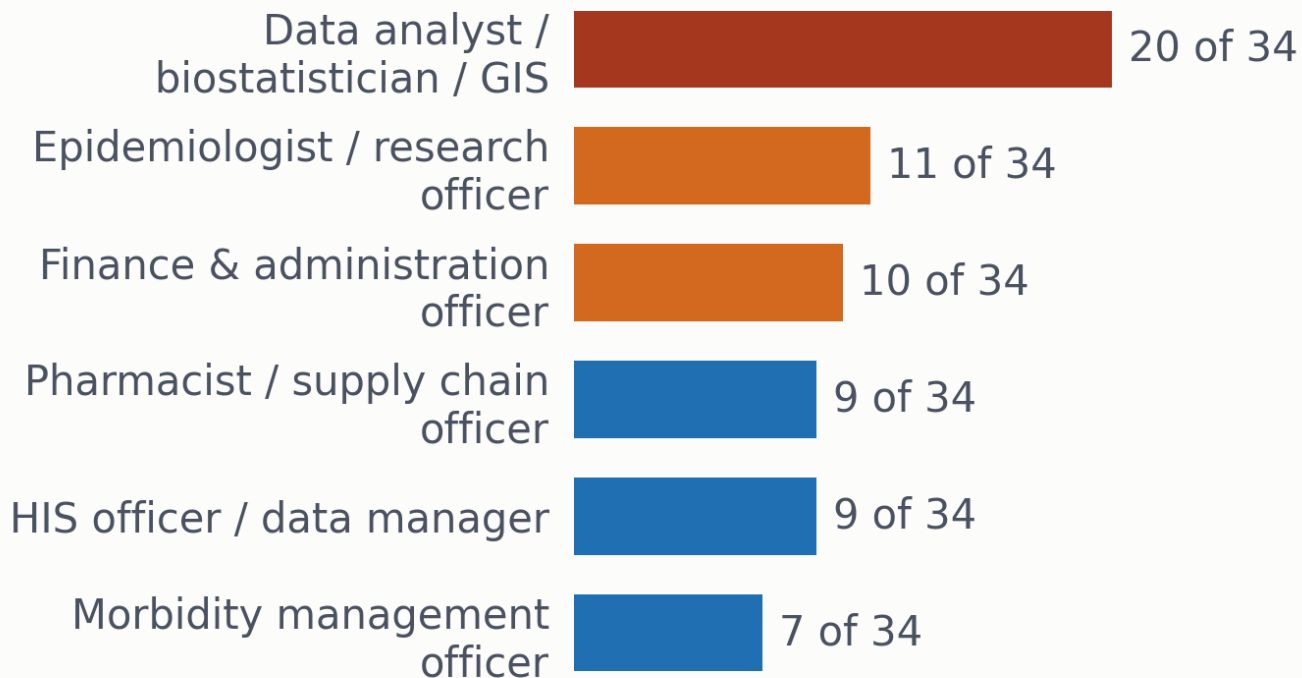
say data are rarely used for decisions anywhere

What would change this: a documented quarterly district data review, and a one-page sheet returning each district its own numbers.

The analytical roles are unfilled — and so is the QA toolbox

Objective 1 · Staffing (G.5) and data management tools (G.1, G.2)

Share of countries reporting ZERO staff in the role



20 of 34

have no data analyst, biostatistician or GIS specialist

17 of 34

have no written SOP for NTD data management

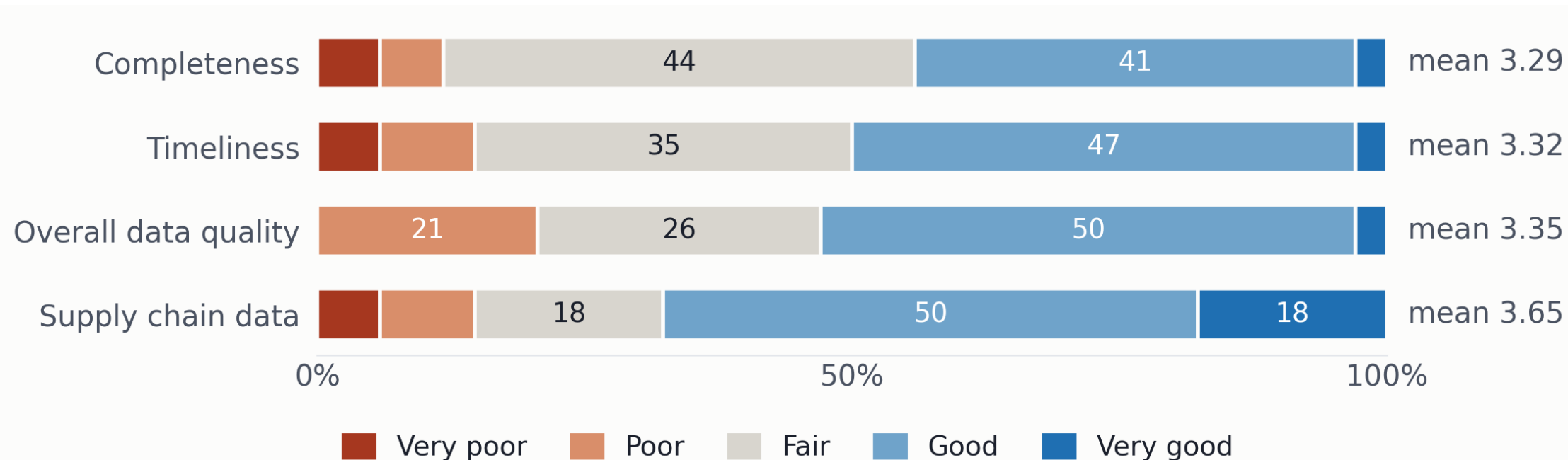
32%

have a data quality checklist — the least available tool of all

Staffing takes years. An SOP and data quality checklist package is the cheapest high-leverage fix available, and could ship this year.

Everyone is "fair to good" — and nobody is a model

Objective 2 · Perceived completeness, timeliness and quality (C.5–C.7, F.3)

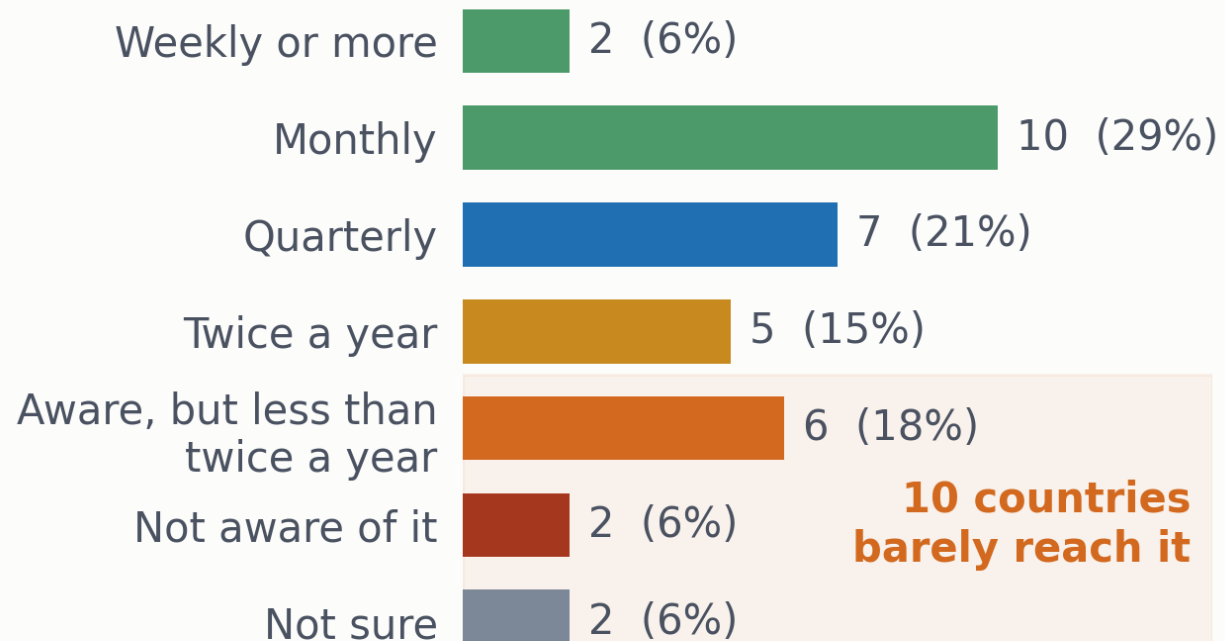


The compression is the finding. Overall quality averages 3.35/5. 21% rate their NTD data poor or very poor, and exactly one country in the whole survey rates any dimension "very good". A Region where everyone sits in the middle has no internal exemplar to copy — an argument for a common regional SOP package, not peer learning alone.

The ESPEN portal has a reach problem, not a product problem

Objective 3 · PC-NTD data shared with ESPEN (D.3) and portal use (E.1–E.3)

How often the national programme uses the ESPEN portal



62%

of portal users rate it very or extremely useful

10 of 34

use it less than twice a year, or are unaware of it

41%

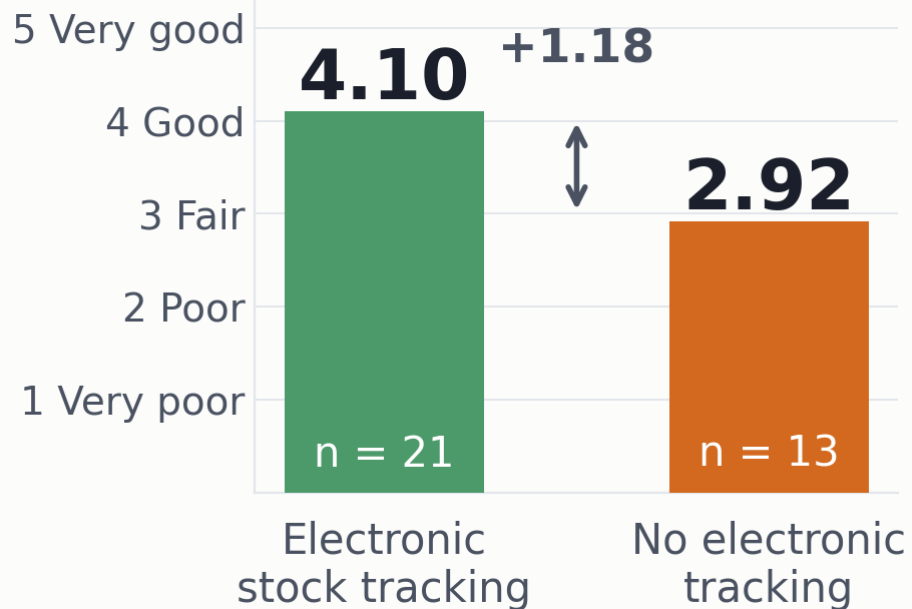
of implementing countries share only PART of their PC-NTD data with ESPEN

Use and perceived usefulness correlate at $r = 0.53$. The portal proves its value on contact — so a targeted onboarding push at the 10 disengaged countries is the highest-return action here.

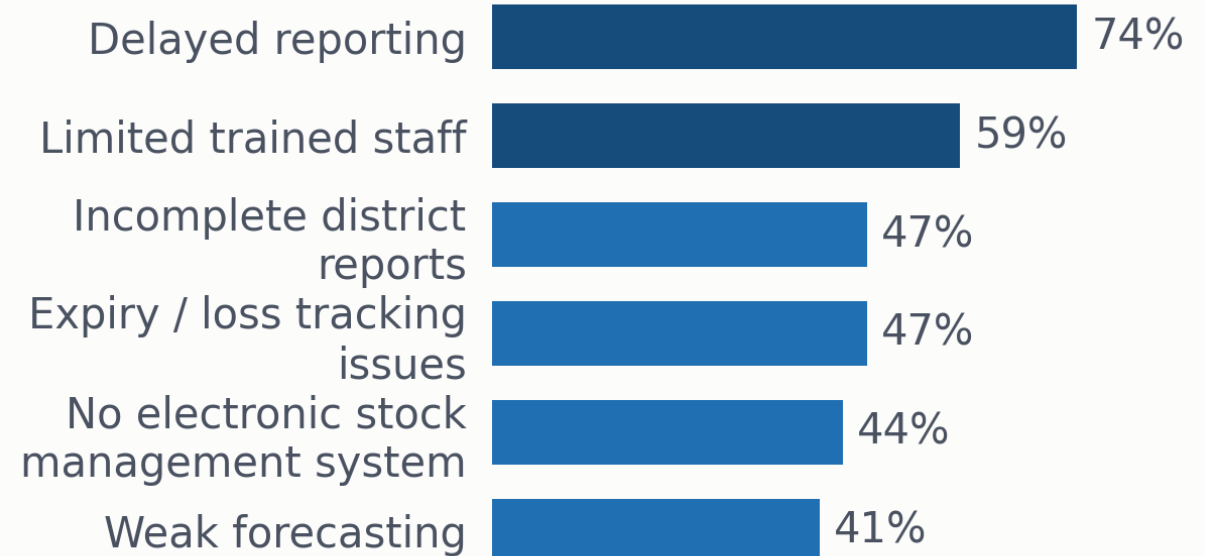
Going electronic is the biggest single difference we measured

Objective 4 · PC-NTD supply chain data (F.1, F.3, F.5)

Perceived quality of stock data (F.3)



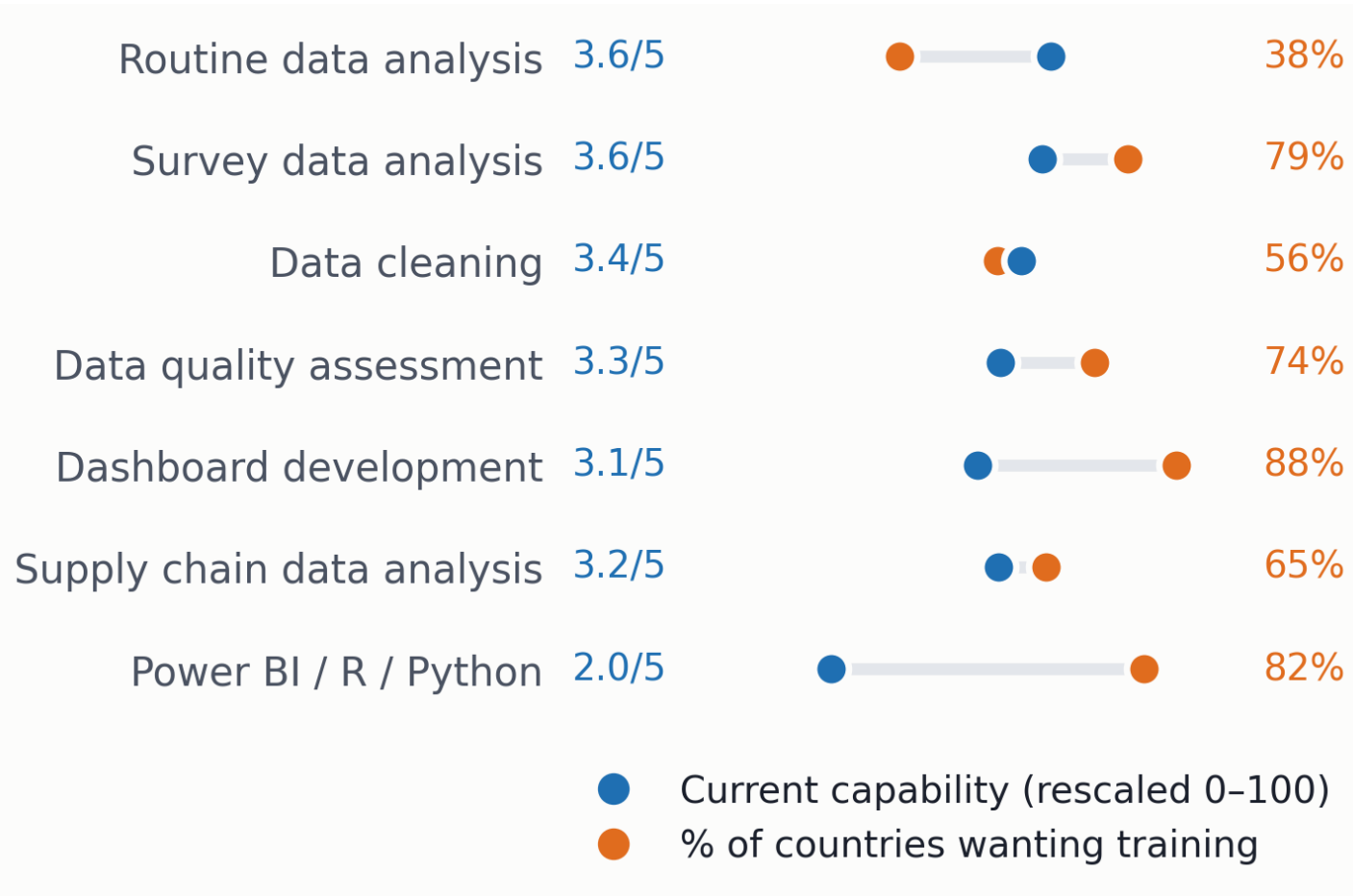
Main supply chain data challenges (F.5)



The widest gap in the survey — and the route is affordable. 50% of countries already have a national LMIS and 27% already use DHIS2 for stock. The task is usually to bring NTD medicines into a system that already exists — configuration and training, not a capital project.

Countries want the tools they are least equipped to use

Objective 5 · Capability (H.2–H.11), training demand (H.12) and infrastructure (G.3, G.4)



41%

have NO computers dedicated to NTD data work

17 of 34

do not have reliably available internet

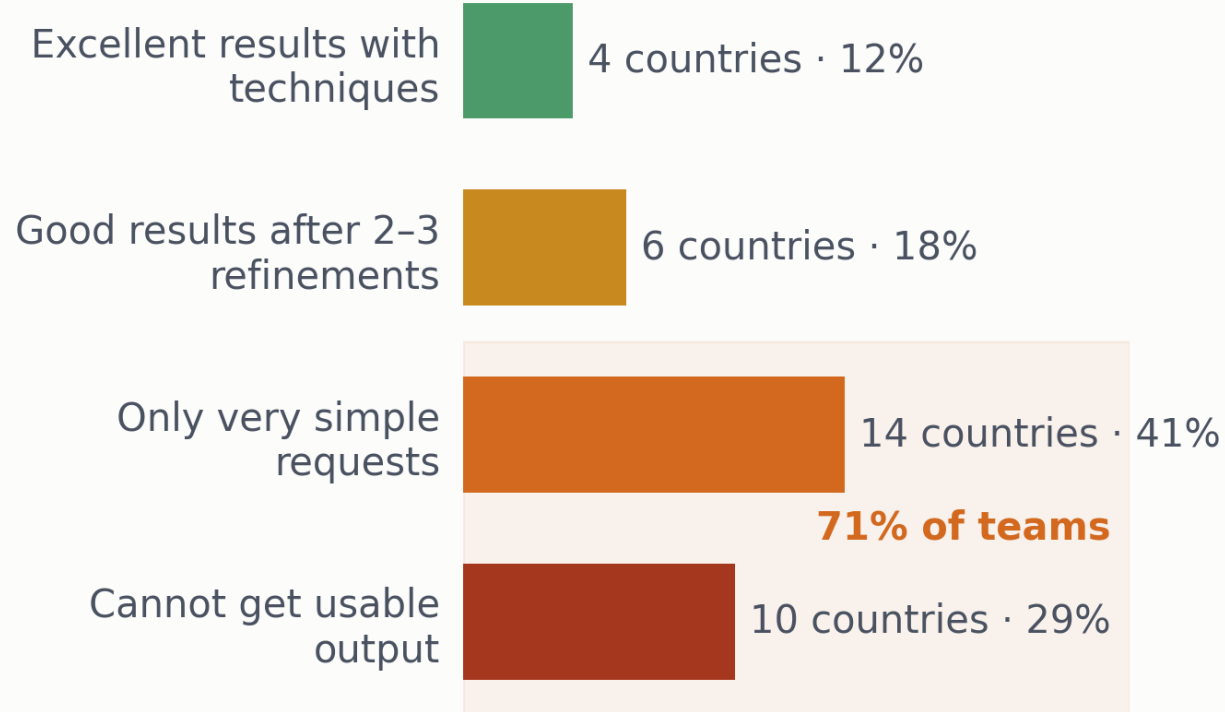
18%

currently use Power BI — while 82% want training in it

The sequencing problem. Training delivered into that environment will not convert into capability. Tier the offer against an equipment and staffing floor.

AI: a level starting line, and a modest, concrete opportunity

Objective 6 · What teams can actually get an AI tool to produce (H.13–H.16)



AI adoption is not following technical strength.

Countries using AI at least monthly have a mean skills index of 3.18. Those that rarely or never use it: 3.18. Identical — $r = 0.08$.

29%

of countries never use AI tools at all

18%

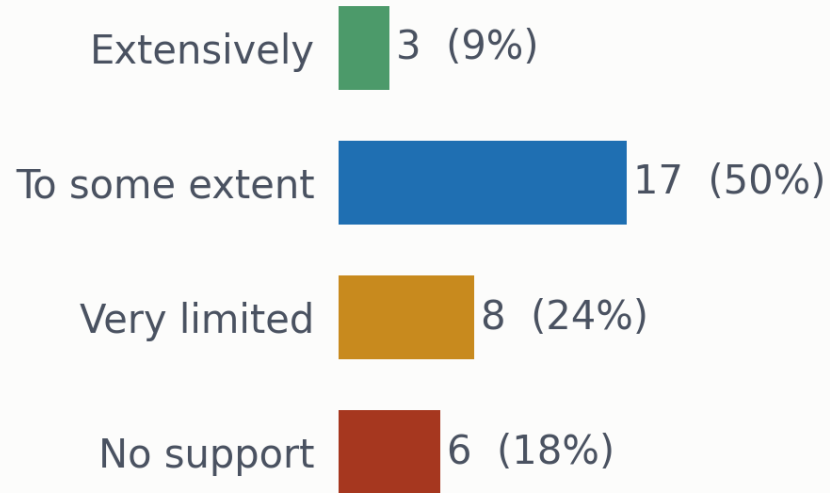
use AI for data processing — the use case closest to their actual work

The one area where an intervention helps the weakest countries as much as the strongest.

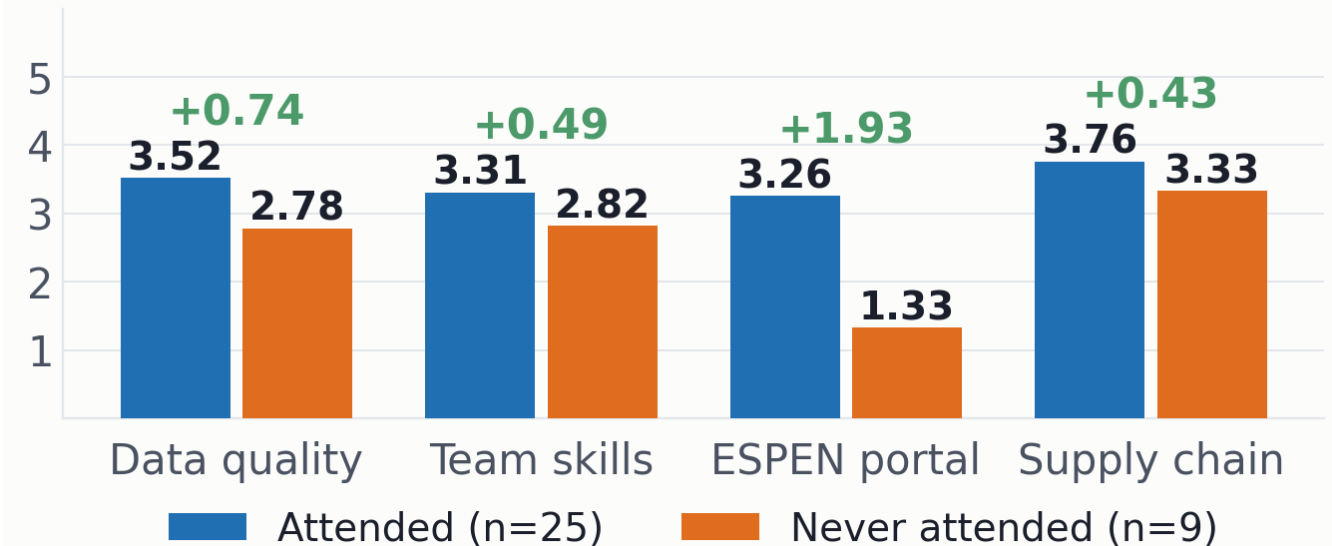
Partner support is thin; our own workshops work but do not reach far enough

Objectives 7 and 8 · Partner support (I.1, I.3) and ESPEN workshop impact (J.1–J.9)

Partner support for NTD data work (I.1)



Capability of workshop attendees vs non-attendees (J.1)



Partners: coordination is fine, targeting is not

57% call support well coordinated — but it clusters on filling JAP forms (61%) rather than equipment (25%), the binding constraint.

Workshops: extend reach, add a refresher cycle

100% of attendees improved JRF preparation. But 9 countries have never attended, and 64% name refresher training as the top barrier to applying what they learned.

Countries need different things — three tiers, not one package

Cross-cutting · Composite maturity score across six structural measures (0–10)

Emerging 0–3 points · 6 countries

Equipment and connectivity, a written SOP, portal onboarding, and the foundational training track only.

Eswatini	3
Botswana	3
Guinea-Bissau	3
Gabon	2
Sao Tome and Principe	1
Equatorial Guinea	0

Developing 4–6 points · 15 countries

Electronic stock tracking, district-level data review, and targeted support on named skill gaps.

Gambia	6
Congo	6
Uganda	6
Lesotho	6
Kenya	6
Mali	6
Côte d'Ivoire	6
Ethiopia	5
Sierra Leone	5
Cameroon	5
Zambia	5
South Sudan	4
United Republic of Tanzania (Mainland)	4
Comoros	4
Mauritania	4

Advanced 7–10 points · 13 countries

Advanced analytics, a dedicated data post, and a role mentoring countries in the other two tiers.

Mozambique	10
Liberia	10
Burkina Faso	9
Rwanda	9
Ghana	9
Niger	9
Zimbabwe	8
United Republic of Tanzania (Zanzibar)	7
Democratic Republic of the Congo	7
Senegal	7
Guinea	7
Benin	7
Burundi	7

Strengths

- DHIS2 platform operational in 33 of 34 countries, most for a decade
- 29 of 34 implemented PC-NTD activities in 2025
- Core data-handling skills are solid (routine reporting 3.62/5)
- Supply chain data rated the best of any data type (3.65/5)
- The ESPEN portal is valued by those who reach it (62%)

Challenges

- Data use collapses below national level (97% → 32%)
- Paper is still the point of capture in 79% of countries
- 20 of 34 have no data analyst, biostatistician or GIS specialist
- Half the Region is equipment- or connectivity-constrained
- 17 countries have no NTD data management SOP

Opportunities

- Electronic stock visibility — a 1.18-point quality difference
- An SOP and checklist package: the cheapest high-leverage fix
- District data review: a routine change, not a technology one
- Portal onboarding for the 10 disengaged countries
- Workshops already work — add a refresher cycle, extend reach

Recommendations and next steps

Twelve recommendations in the report · the three highest-return actions shown in full

R1 Set and fund a minimum NTD data workstation standard

One dedicated computer, reliable connectivity and a defined district package — an explicit line in national workplans and partner asks, and the gate for the advanced training track.

17 of 34 constrained (G.3, G.4)

R2 Bring NTD medicines into an electronic stock system

Target the countries with none. Route through the existing national LMIS or a DHIS2 stock module rather than building anything new, paired with a standard monthly stock-status report.

1.18-point quality gap (F.1, F.3)

R3 Publish an SOP and data quality checklist package

A short adaptable regional template — deadlines, validation rules, roles, checklist — localised by each country in a facilitated session rather than emailed as an attachment.

17 countries have no SOP (G.2)

Next steps. 1 · Send each country its profile from Annex A and invite correction. 2 · Verify the four flagged records and reconcile the two workbook sheets. 3 · Follow up Chad and the non-responding countries. 4 · Cost R1–R3 before the next JRSM cycle. 5 · Repeat the survey in 2027 with the instrument fixes.

Five things to remember

Full analysis and country profiles in the accompanying report.

- 1 The Region built the system. It has not yet built the habit of using it.
- 2 Quality is lost in the last mile — and the tools to fix it are the ones we never supplied.
- 3 Electronic stock visibility is the clearest single lever we found.
- 4 We are being asked for Power BI by countries that do not have computers.
- 5 What ESPEN already does works. It needs to reach further and last longer.



•THANK
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Updates on Trachoma

Amir Kello, Medical Officer Trachoma

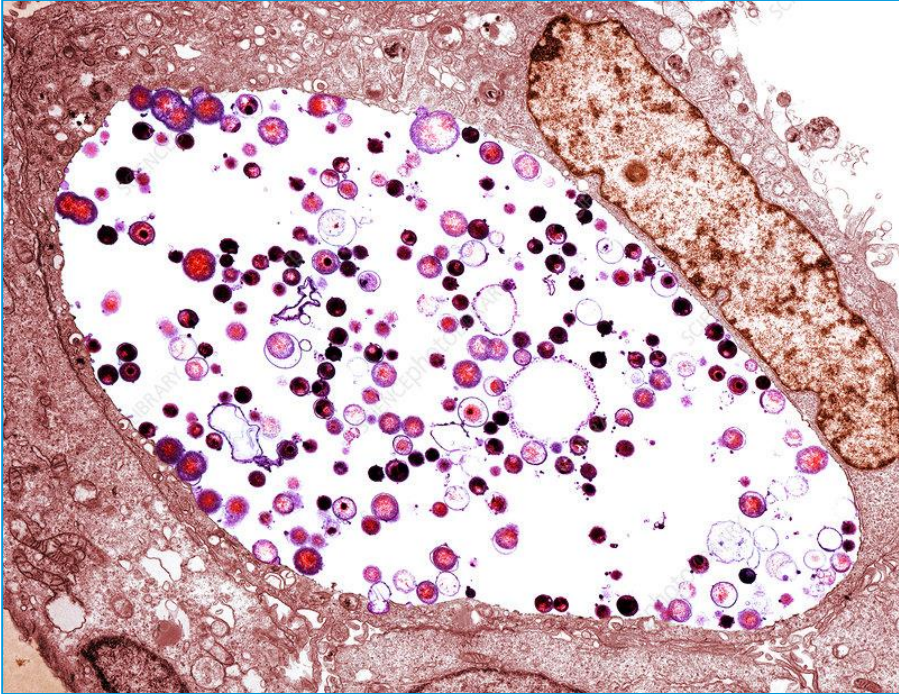


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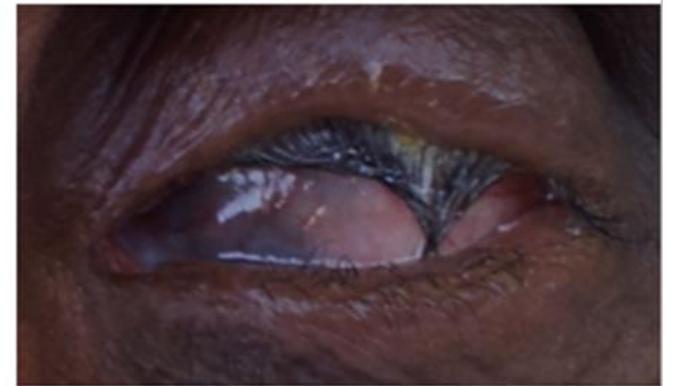
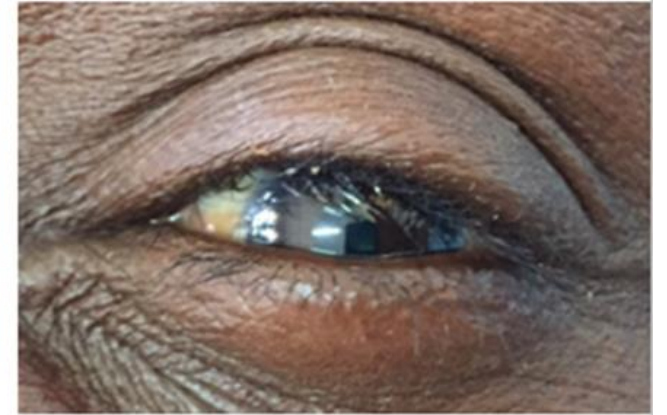
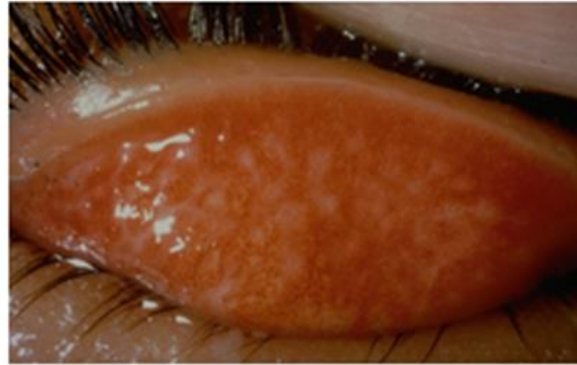


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TRACHOMA



1.9M VI or blind



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FOR ALL



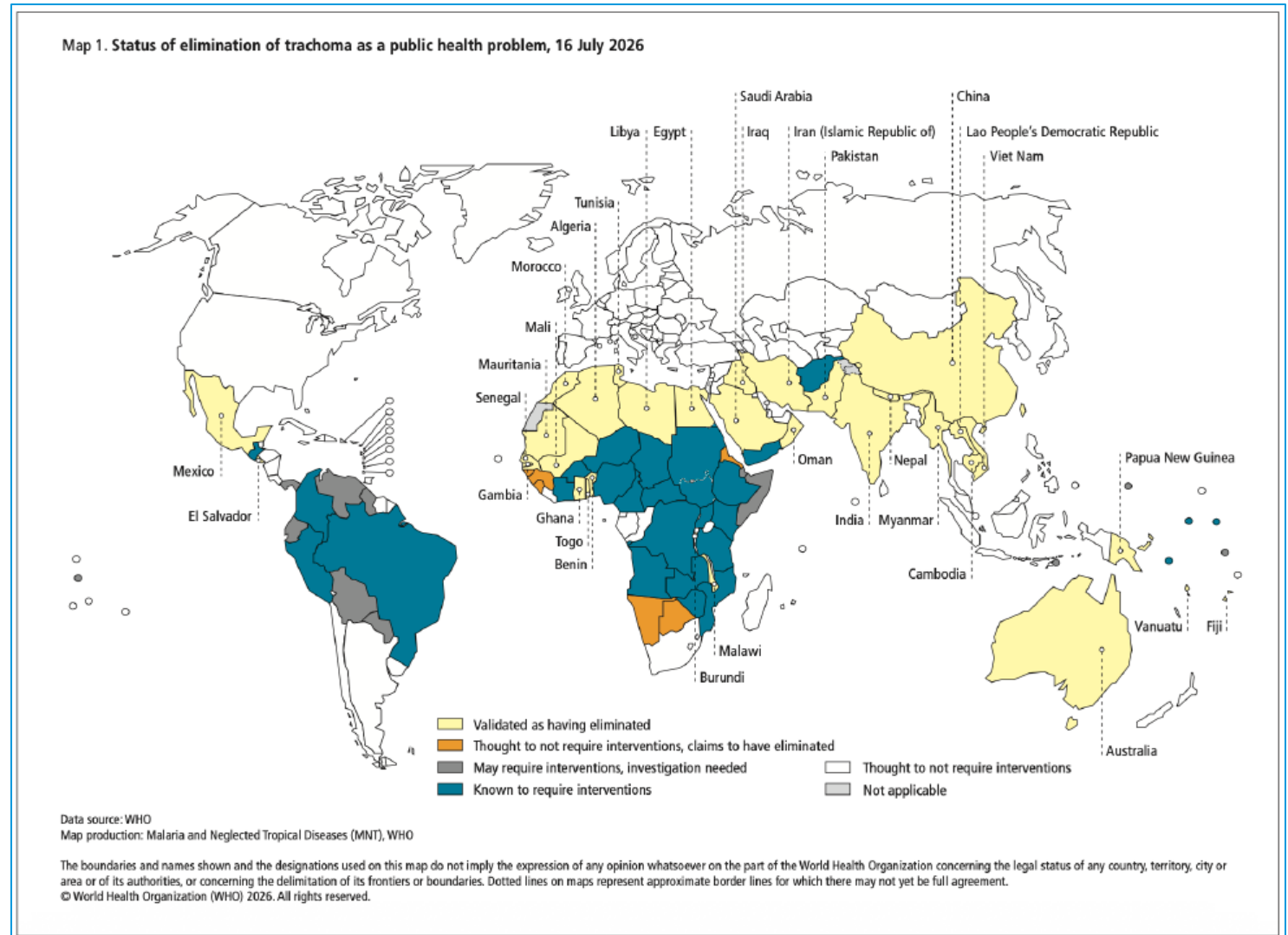
SAFE Strategy

- **S**urgery
- **A**ntibiotics
- **F**acial cleanliness
- **E**nvironmental improvement



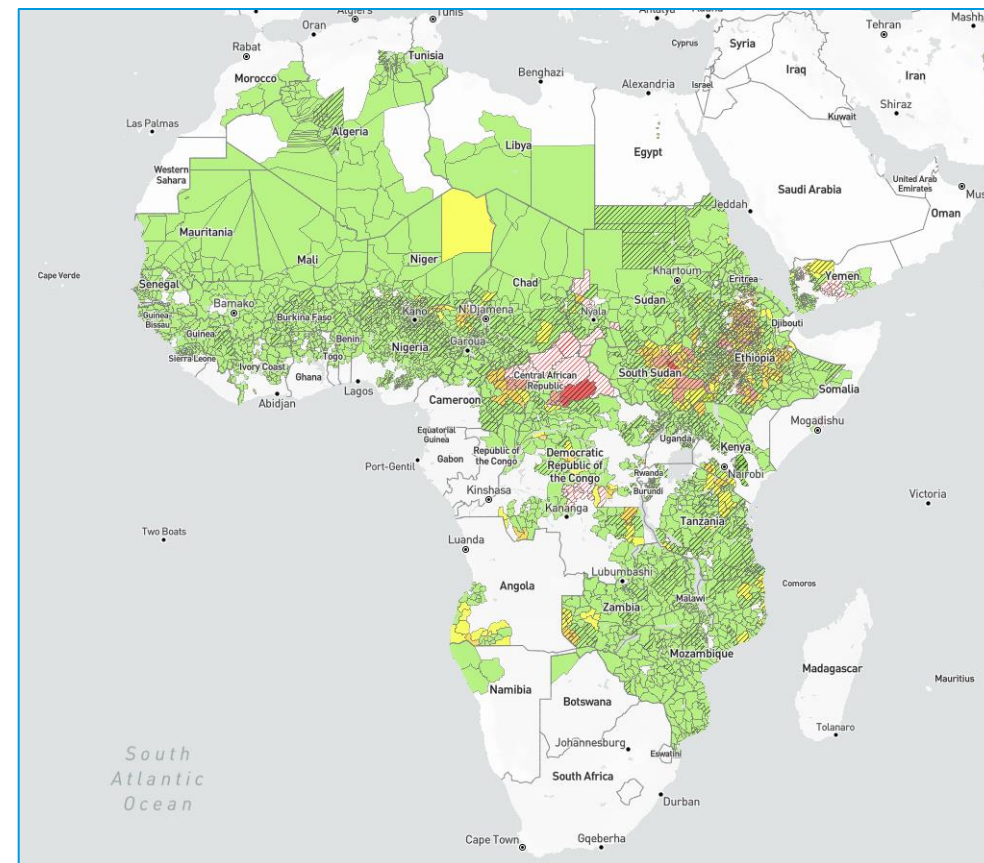
Trachoma Burden – Global (Mar 2026)

- 29 countries
- 92M at risk
- 1.16M TT cases
- 32 validated (Aug 2026)
 - 10 in AFR



Trachoma in WHO African Region (Mar 2026)

- 17/47 countries - PHP
- 87M at risk
- 95% of global
- 1M TT cases
 - 86% of global
- In 2025
 - TT surgery: 97,943 in AFR (99% of global)
 - MDA: 46.6M (98% of global)



LEGEND
TF Prevalence
■ <5%
■ 5-9.9%
■ 10-29.9%
■ 30-49.9%
■ ≥50%
▨ Suspected Endemic

TT Prevalence
▨ ≥0.2%

<https://atlas.trachomadata.org/>



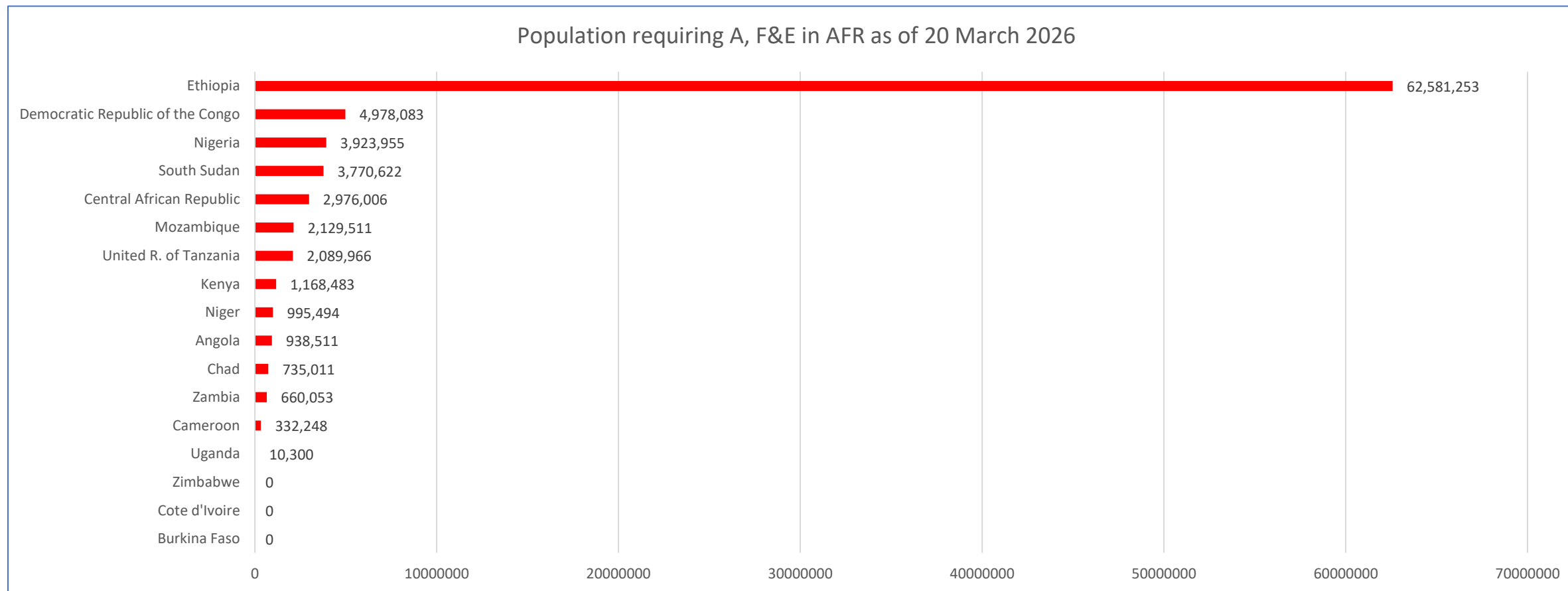
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Population requiring A, F&E in AFR (20 Mar 2026)

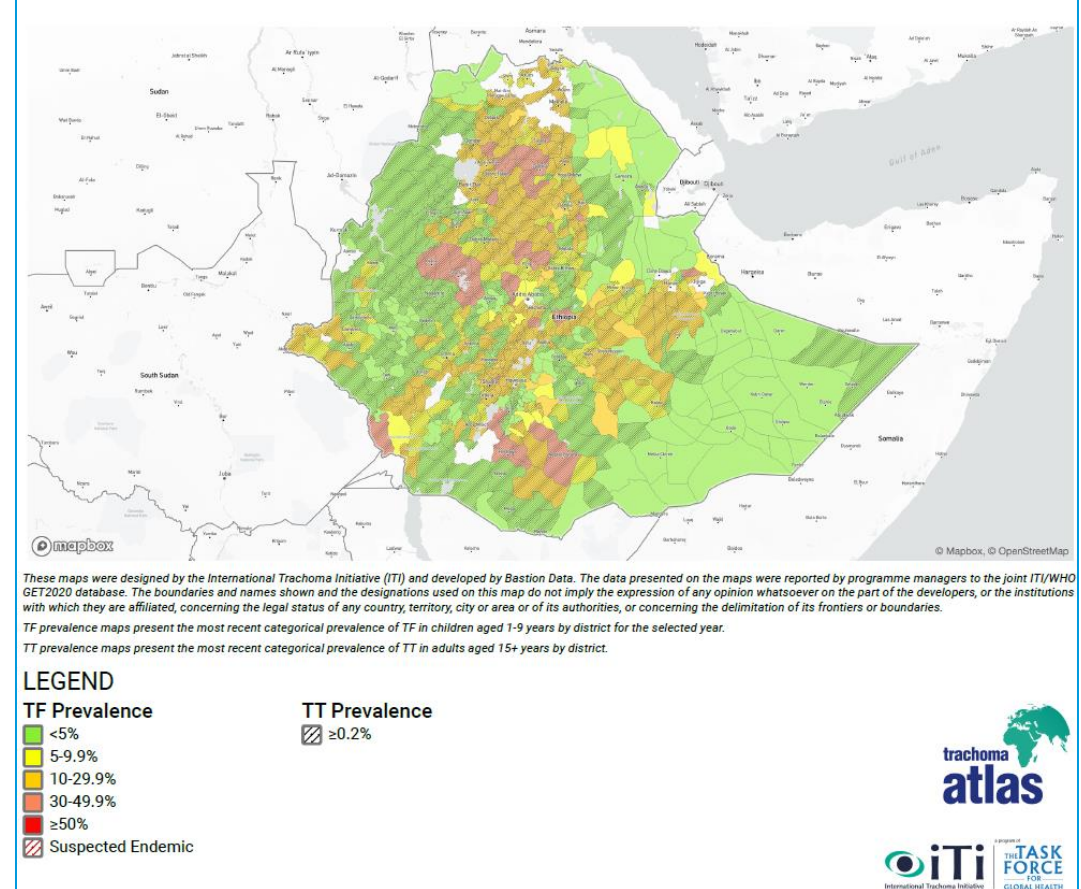


Trachoma Burden in ETH (Mar 2026)

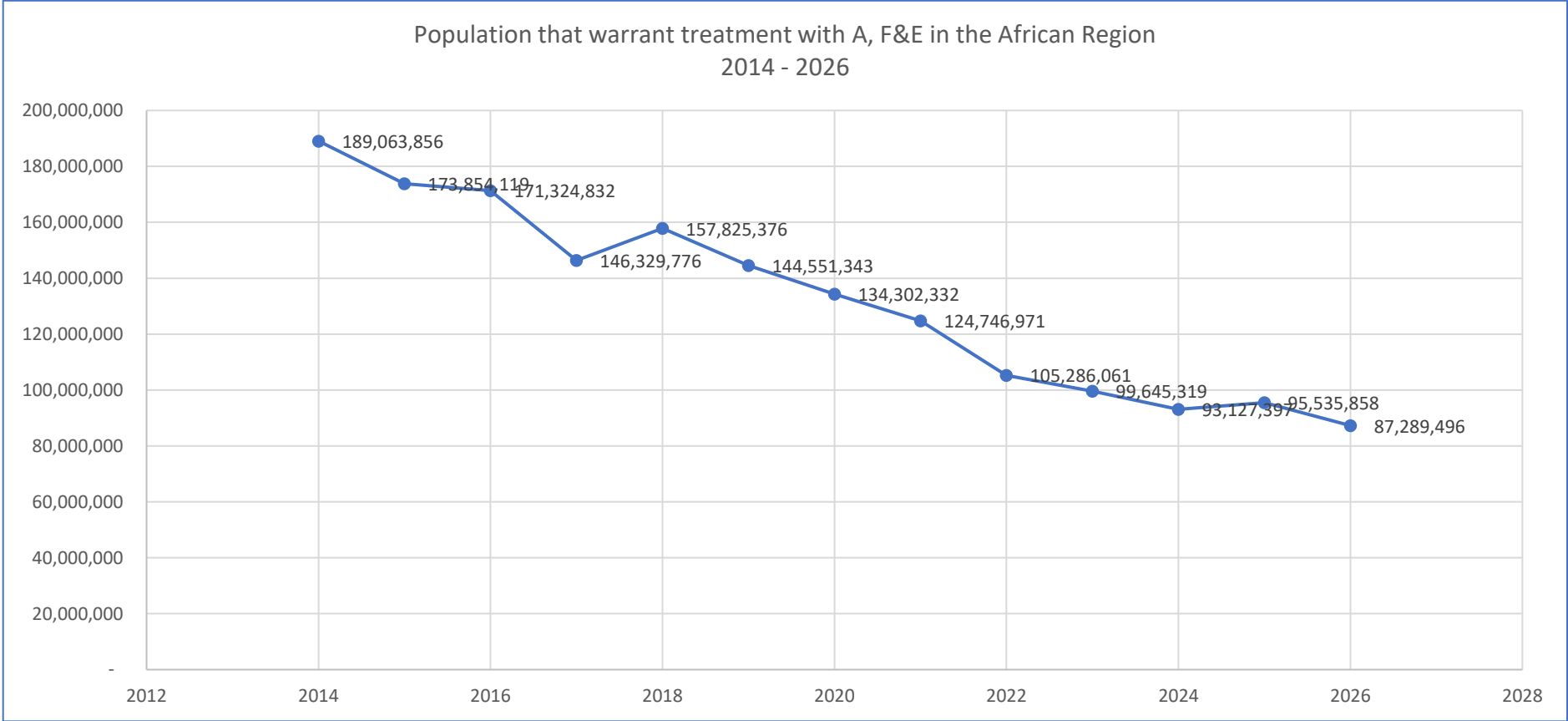
- Ethiopia: 63M at risk
 - 68% of global
 - 72% of AFR
- TT unknown to HS: 433,737
 - 36% of global
 - 43% of AFR

Source: WHO Alliance for GET2020 Database as of 20 March 2026

2026 TF Prevalence, TT Prevalence in Ethiopia



Population Living in at Risk Areas in the AFR (2014-2026)



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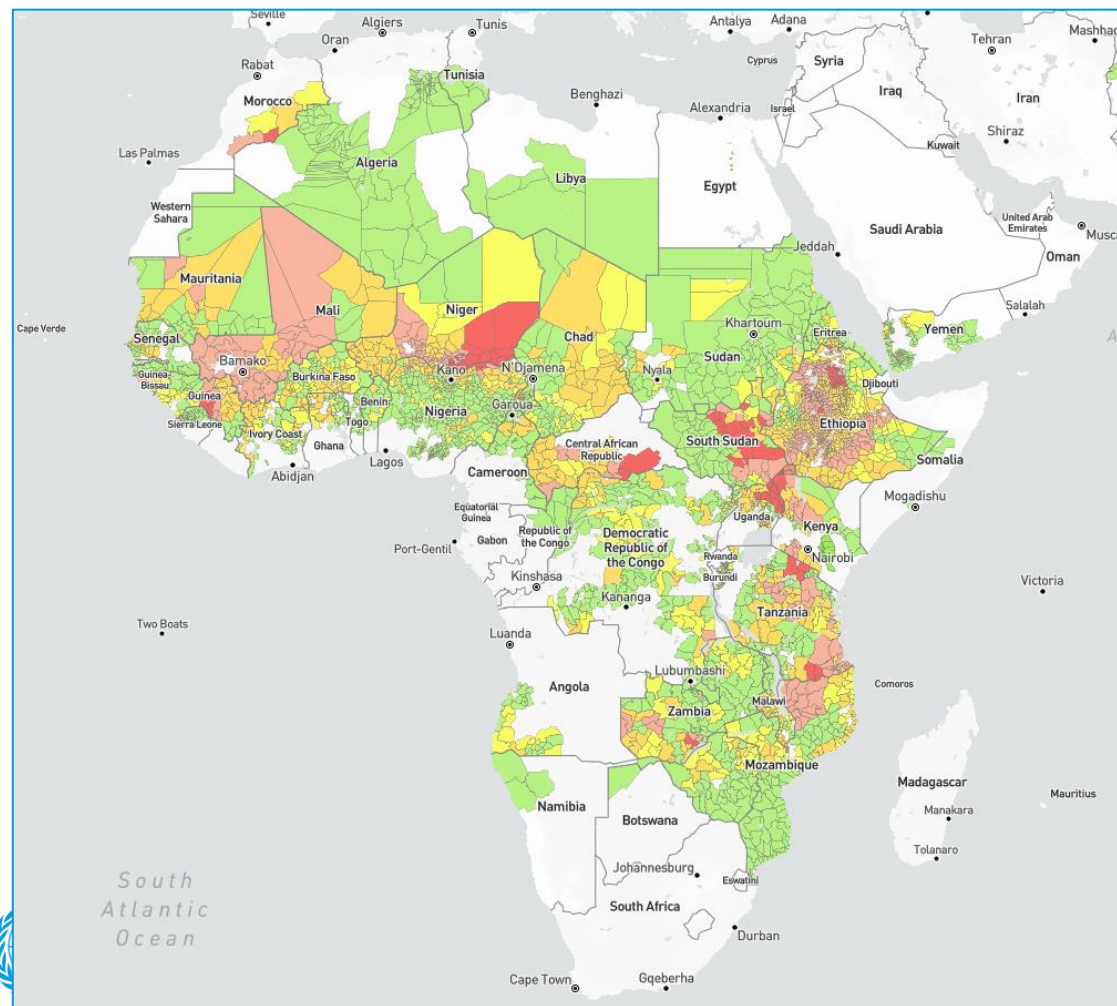


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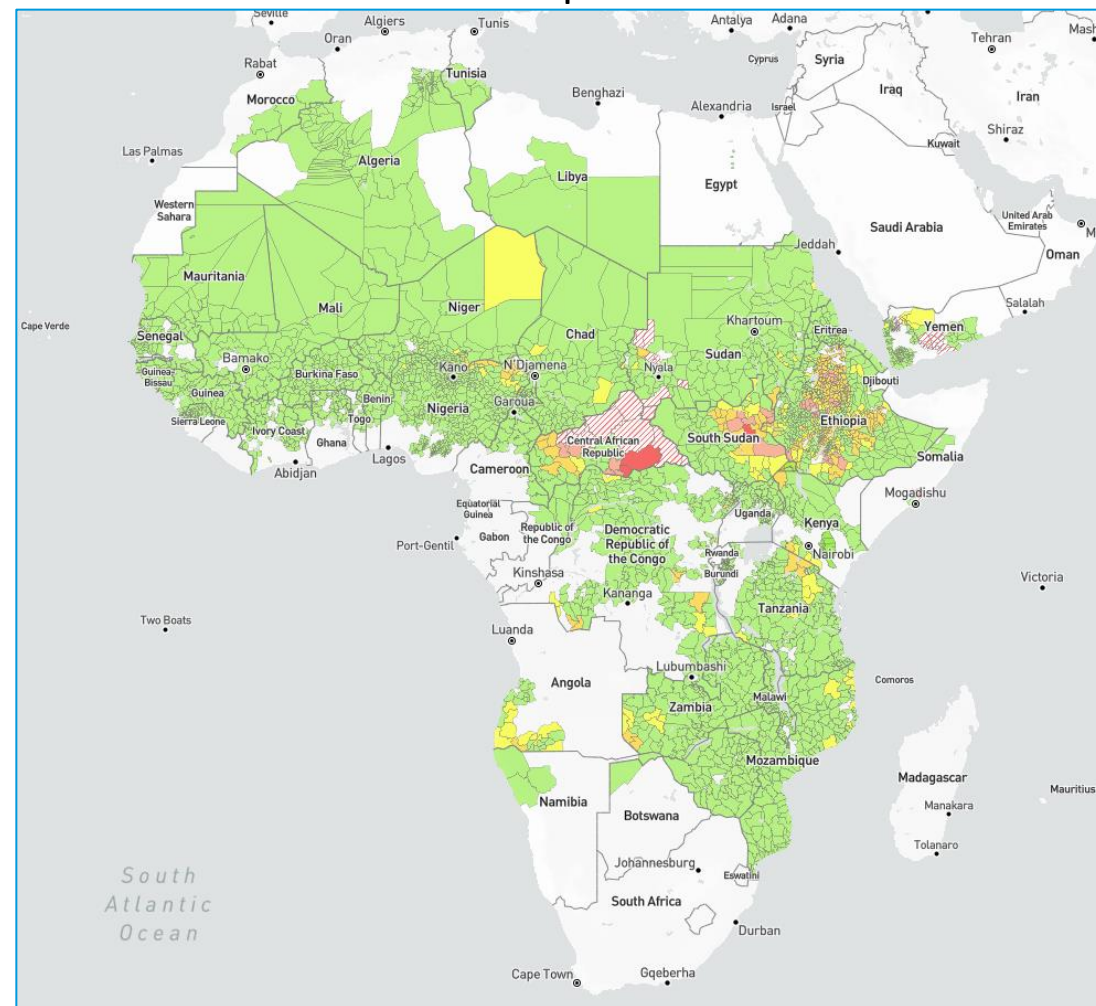


Progress in Elimination of Trachoma in AFR

Baseline TF prevalence



Current TF prevalence



Status of Trachoma Elimination in the African Region (Aug 2026)

Countries thought not to require intervention

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

Countries that may require interventions; investigation needed

None!

Countries known to require intervention

1. Angola
2. Burkina Faso
3. Cameroon
4. Central African Republic
5. Chad
6. Côte d'Ivoire
7. Democratic Republic of the Congo
8. Ethiopia
9. Kenya
10. Mozambique
11. Niger
12. Nigeria
13. South Sudan
14. Uganda
15. United Rep. of Tanzania
16. Zambia
17. Zimbabwe

Countries thought not to require interventions; claim to have eliminated

1. Botswana
2. Eritrea
3. Guinea
4. Guinea-Bissau
5. Namibia
6. Sierra Leone

Validated to have eliminated trachoma as a PHP

1. Ghana
2. Gambia
3. Togo
4. Malawi
5. Benin
6. Mali
7. Mauritania
8. Burundi
9. Senegal
10. Algeria



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Challenges in AFR

- Pending completion of BL mapping
- Reaching the TT threshold for EPHP
- Persistent and recrudescent active trachoma
- Lack of funding
- Cross-border issues
- Hard to reach areas & special populations
- Insecurity

Priorities in AFR

- Supporting completion of BL mapping in Angola, CAR & DRC
- Supporting reaching 100% geographic coverage for MDA and TT surgery
- Addressing persistent and recrudescant districts
- Reaching special populations & “insecure” areas
- Cross-border collaborations
- Supporting countries with TRA elimination dossiers
- Post-validation surveillance



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Schistosomiasis Elimination in the Africa region

Pauline Mwinzi, Technical Officer SCH/STH



Outline



About schistosomiasis and clinical manifestation

Global updates

Regional updates

Global and Regional targets 2025, 2030

Summary of Schistosomiasis guidelines 2022

The SCH/STH M&E Draft Framework 2024

Updating population requiring treatment

Strategic interventions and new focus areas

- Treatment of preschool age children
- Female genital schistosomiasis and other morbidities
- Control of zoonotic schistosomiasis
- Snail control
- Climate change

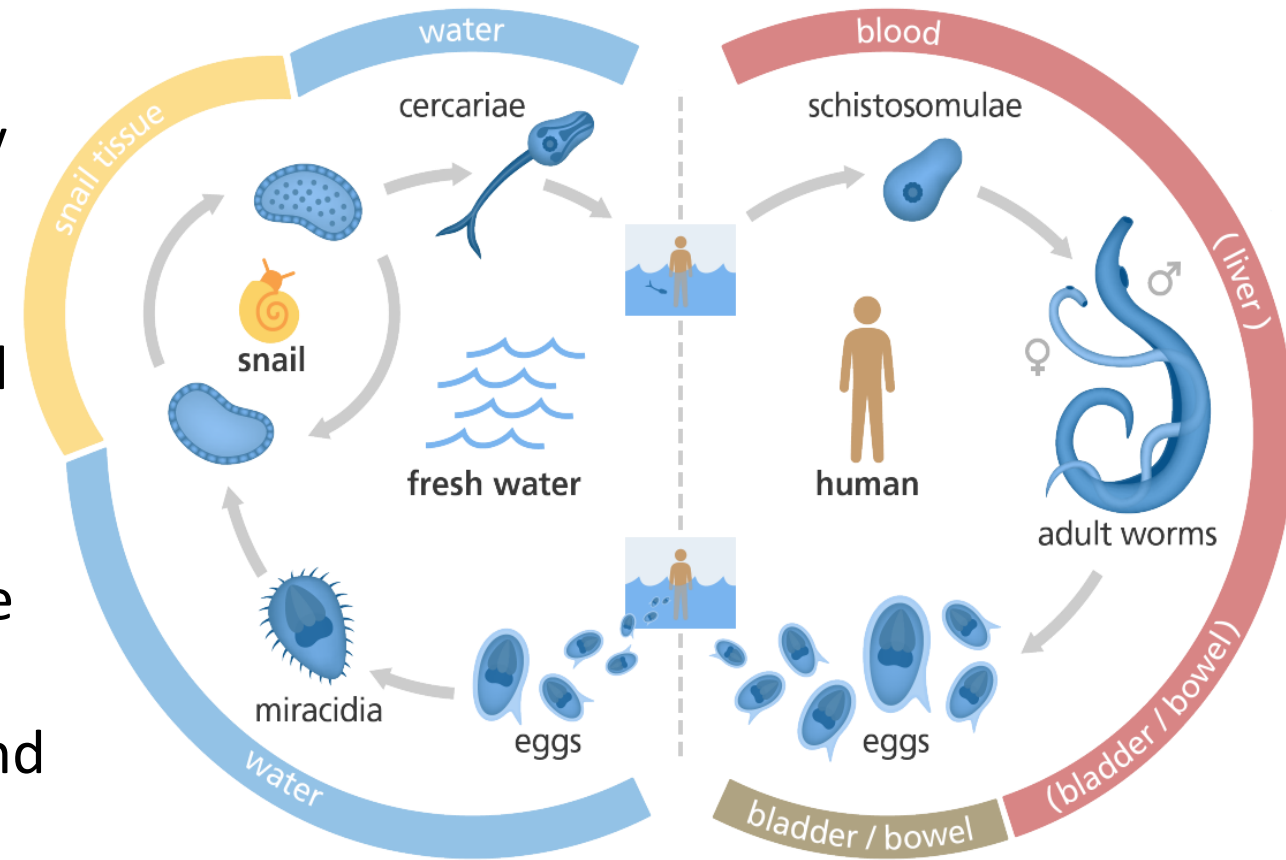
Knowledge gaps

Challenges

Resource gaps

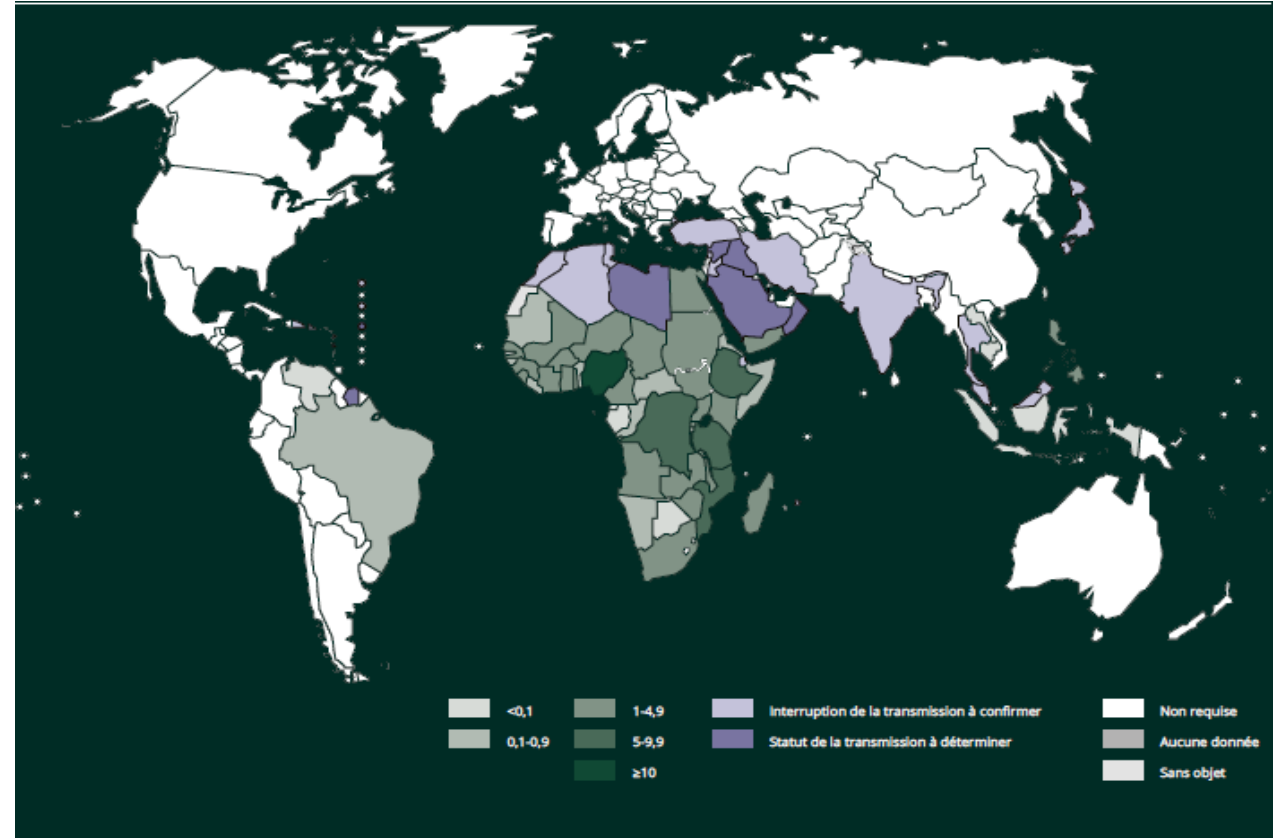
Schistosomiasis

- Snail-borne parasitic disease transmitted by transcutaneous inoculation of the worms' larvae
- Transmission is sustained by urine and fecal contamination of fresh-water bodies and is facilitated by poor hygiene and sanitation
- Adult worms live in the bloodstream, where female release eggs
- Circulating eggs lodge in different organs and are responsible for pathology through inflammation of surrounding tissues



Global situation of schistosomiasis

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



Schistosomiasis: clinical manifestations



Bloody urines

- Haematuria (blood in urine)
- Bladder inflammation eventually leading to kidney dilatation and bladder cancer
- Genital polyps, papulae and ulcers, bleeding, pelvic pain, dyspareunia, ectopic pregnancy, hemospermia, sterility

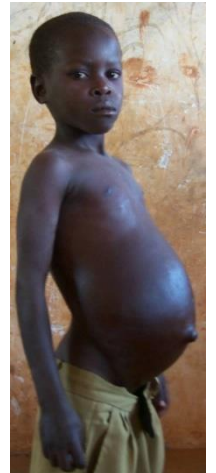
Urinary
schistosomiasis



Bloody stools

- Blood in stool
- Diarrhoea
- Portal hypertension
- Ascites and oesophageal varices, hematemesis

Intestinal
schistosomiasis

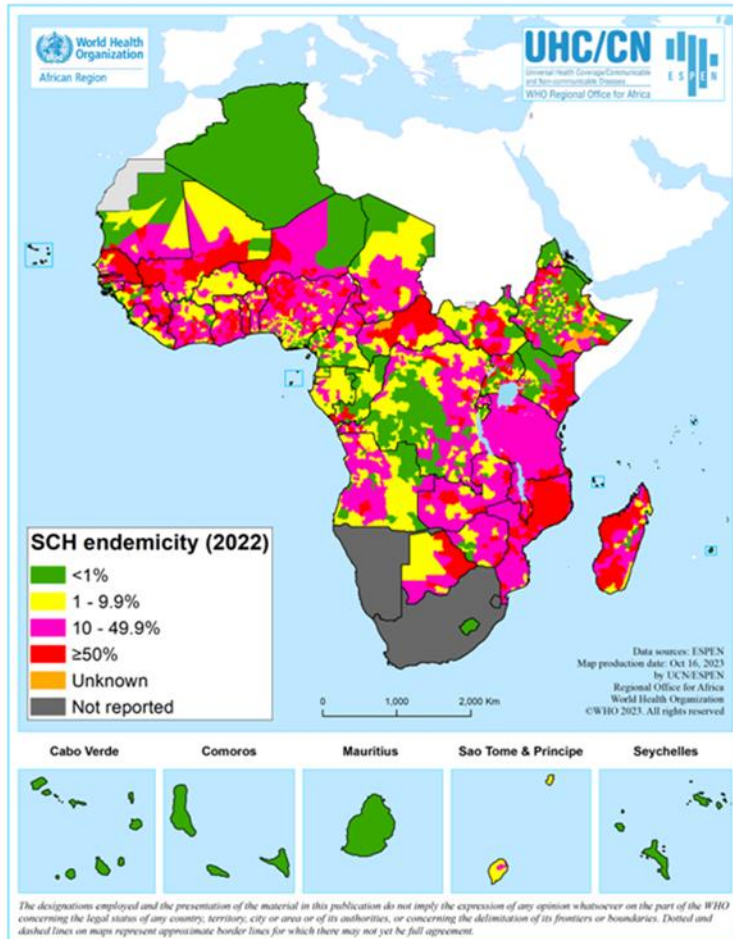


**Hepato-splenomegaly
Ascitis**

2030 target for SCH

Disease	2030 Global Targets	Thresholds for declaring the infection eliminated as a public health problem
SCH	• To eliminate the disease as a public health problem in all endemic countries	• 1% prevalence of heavy intensity infections in all formerly endemic units • Reduction of prevalence to levels <10% at community levels

Schistosomiasis Elimination progress



43 countries considered endemic and 41 countries (*42 NTD programmes) requiring PC

Only 2 countries, Eq. Guinea and South Africa, are the last to start PC in 2024.

Cape Verde, Comoros, Lesotho, and Seychelles considered non-endemic, and transmission not confirmed in Algeria

60.6% (51% - 75.5%) coverage achieved on school-age children (SAC) between 2014 and 2022.

Low coverage in adults (15.4% in 2022) due to limited donation of PZQ

558.5M treatments delivered to school-aged children since 2014.

Total treatments delivered to 85.2M people (SAC & adults) in 2022.

Sub-district stratification to better target treatment is on-going.

Status of countries and territories endemic for schistosomiasis in 2025

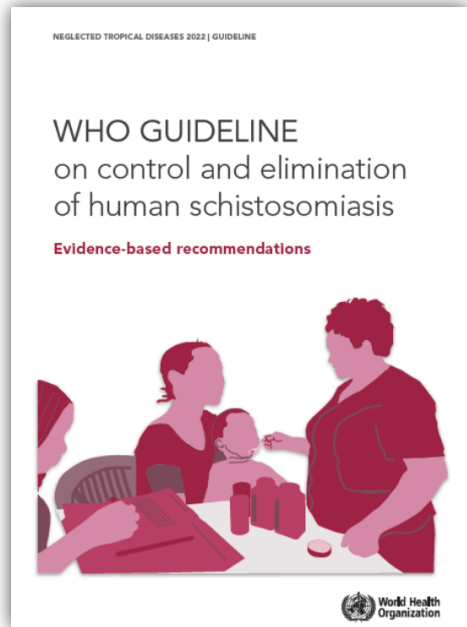
41 countries requiring preventive chemotherapy in Africa

- WHO Africa region is made up of 47 countries
- 44 are endemic for schistosomiasis and 41 require PC except Mauritius and Algeria
- **Cabo Verde is newly endemic**
- Non-endemic countries are Comoros, Lesotho, and Seychelles

Mapping not started	First MDA piloted in 2024	MDA started but not at scale or irregular	MDA scaled to all endemic IU*s	Readiness to prepare elimination dossiers	Need evaluation to verify interruption of transmission	Dossier submitted
Cabo verde	Equatorial Guinea, South Africa. MDA started in Q1 2024	Angola, Congo, Nigeria (some LGAs), Central African Republic, Chad, Gabon, Guinea-Bissau, South Sudan, Zambia, Botswana, Namibia.	Benin, Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Egypt, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Rwanda, Senegal, Sierra Leone, Sudan, Eswatini, Togo, United Republic of Tanzania, Uganda, Yemen, Zimbabwe.	2026-2028: Burkina Faso Burundi Rwanda 2030: Cote d'Ivoire Burundi Togo Sao Tome and Principe Ghana Nigeria Malawi Eritrea	Mauritius	Algeria

*IU. Implementation unit

Schistosomiasis guidelines 2022



Annual PC with single dose PZQ at $\geq 75\%$ treatment coverage in all age groups from 2 years old, in endemic communities with prevalence of *Schistosoma* spp. infection $\geq 10\%$



In endemic communities with prevalence of *Schistosoma* spp. infection $< 10\%$:

(i) where there has been a programme of regular preventive chemotherapy, to continue the intervention at the same or reduced frequency towards interruption of transmission;

(ii) where there has not been a programme of regular preventive chemotherapy, to use a clinical approach of test-and-treat



Biannual (twice yearly) PC in endemic communities with prevalence of *Schistosoma* spp. infection $\geq 10\%$ that demonstrate lack of an appropriate response to annual preventive chemotherapy, despite adequate treatment coverage ($\geq 75\%$)



Health facilities provide access to treatment with praziquantel to control morbidity due to schistosomiasis in all infected individuals regardless of age



WASH interventions, environmental interventions (water engineering and focal snail control with molluscicides) and behavioural change interventions as essential measures to help reduce transmission of *Schistosoma* spp. in endemic areas.



In communities approaching the interruption of transmission (no autochthonous human cases reported for 5 consecutive years),

-Testing for *Schistosoma* infection in humans with a diagnostic that has high sensitivity and specificity.

-Testing for *Schistosoma* infection in snails with a diagnostic that has high sensitivity and specificity.

-Testing for *Schistosoma* infection in non-human mammalian hosts, as applicable, with a diagnostic that has high sensitivity and specificity.

Five main strategic interventions

- **Preventive chemotherapy (mass treatment)**

- Large-scale distribution of medicines to entire population groups

- **Individual disease management**

- Patient-focused detection, diagnosis, treatment and follow-up

- **Intersectoral strategic interventions**

- Snail control: **Global Vector Control Response 2017-2030**
- Veterinary public health: **One Health, Zoonotic schistosomiasis**
- WASH: **Global Strategy on WASH & NTDs**

Targeting humans



Key intervention area		Progress	Gaps	Current actions
1. PC		All countries now routinely use community level data	Impact assessments are not timely due to inadequate funding PC for adults	Data analysis and advocacy for funding for data and PC gaps
	1a. PSAC	WHO pre-qualification of rPZQ May 2024	Country preparation for roll out	Regional data support for partners/stakeholders working on rolling out rPZQ
	1b. WRA	WRA treatment policy	Medicine availability	Advocacy for treatment platforms, estimation of WRA populations
2. Case management, MMDP, FGS/MGS		Tools available with various partners	Harmonization and standardization of tools	Harmonization of different survey and intervention tools
3. Infected snail control		Tool ready: Guidelines and manuals	Funding, capacity and planning gaps	Mapping of areas that need action, advocacy
4. WASH		Tools for data collection community actions are available	Data available in countries not routinely shared to ESPEN	Inclusion of WASH cross-sectoral planning in NTD MPs
5. Zoonotic SCH		WHO guidance manual now finalized	Funding and advocacy	<i>T.sol</i> integration in pilot 5 countries in progress

Preventive chemotherapy



WHO recommends regular treatment through mass drug administration (MDA) with praziquantel (PZQ) of at-risk groups

- Referred to as preventive chemotherapy (PC)

PC with PZQ is the mainstay of schistosomiasis control

- Safe, efficacious and easily administered

Between 2010 to 2020, WHO has coordinated donations of praziquantel that were used to treat over 626 million SAC

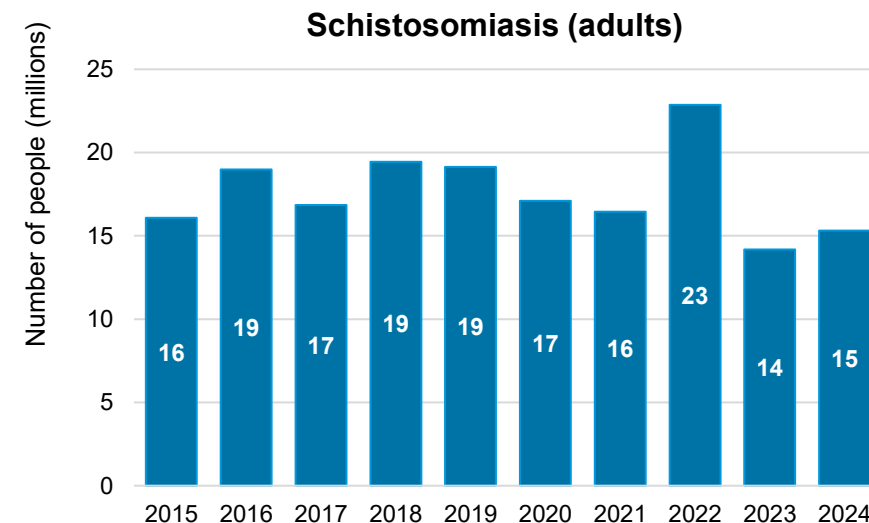
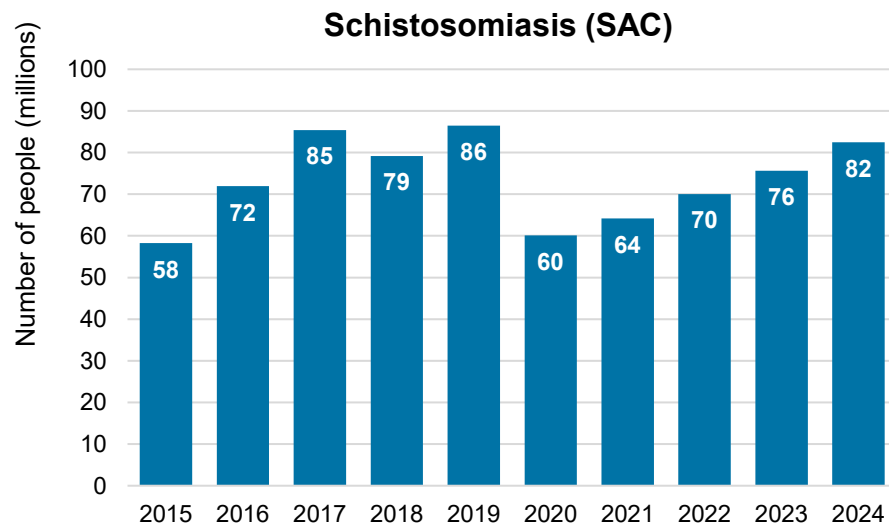
- Resulted in significant reduction in prevalence, intensity and morbidity

PC is not readily accessible by all

- Only in 2022 that WHO recommended extension of PC to all people at risk from 2 years of age in communities with a $\geq 10\%$ prevalence

PC remains a short-term solution to control and elimination of schistosomiasis

Schistosomiasis treatments in 2024



- **100.5** million treated globally in 2024 (**82.7 M SAC** and **15.7 M adults** and **0.2 M PSAC**) in 35 countries
- 89.9 M treated in 2023
- **171,045 PSAC** were treated in the United Republic of Tanzania (Zanzibar) and Gambia using crushed PZQ tablets
- No MDA in 2024 in 10 countries :Mozambique, Sudan, South Sudan, Zambia, Gabon, STP, Namibia, Eritrea, Congo and Equatorial Guinea

Emerging focus areas for elimination goals

- As the goal for schistosomiasis has changed from control to elimination as Public Health Problem Schistosomiasis in School age children the following previously neglected intervention areas become more urgent:



- Treatment of preschool age children
- Female genital schistosomiasis and other morbidities
- Control of zoonotic schistosomiasis
- Snail control
- Climate change

Schistosomiasis in Pre-School Age Children (PSAC)



*Hepatomegaly and fibrosis have been demonstrated in young children with *S. mansoni* infections*

Morbidity in PSAC. Ultrasound assessment of morbidity to *S. haematobium* in Mali

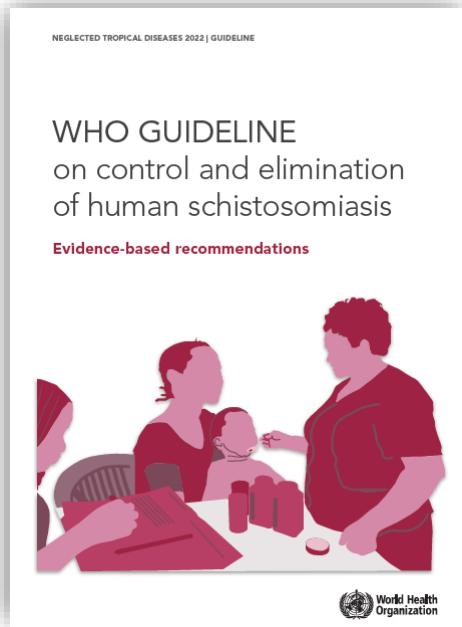
Age-specific prevalence rates of infection and of morbid conditions by age, all villages combined

	Age (years)				All ages
	2-6	7-14	15-24	≥25	
Infection rate	52.8	74.2	62.4	43.2	55.2
Heavy infection rate*	10.7	23.8	7.1	4.8	10.4
Macrohematuria	33.3	50.2	34.1	12.9	28.5
Dysuria	26.6	32.0	33.5	36.1	33.0
Microhematuria	43.1	71.5	49.5	36.1	47.6
Proteinuria	44.7	62.1	41.3	27.6	40.8
Bladder abnormalities	32.9	44.8	21.6	17.2	27.0
Ureter dilatation	18.8	29.9	14.6	12.7	17.9
Pyelon dilatation	12.1	16.6	22.7	15.3	16.2

* ≥50 eggs/10 ml of urine.

Traore M et al. The public health significance of urinary schistosomiasis as a cause of morbidity in two districts in Mali. [Am J Trop Med Hyg.](#) 1998 Sep;59(3):407-13.

New SCH guideline recommendations on treatment



Recommendation 1

In endemic communities with prevalence of *Schistosoma* spp. infection $\geq 10\%$, WHO recommends annual preventive chemotherapy with a single dose of praziquantel at $\geq 75\%$ treatment coverage in **all age groups from 2 years old**, including adults, pregnant women after the first trimester and lactating women, to control schistosomiasis morbidity and advance towards eliminating the disease as a public health problem.

- *Strong recommendation*
- *Certainty of evidence: moderate*

Recommendation 4

WHO recommends that health facilities provide access to treatment with praziquantel to control morbidity due to schistosomiasis in all infected individuals regardless of age, including infected pregnant excluding the first trimester, lactating women and **pre-SAC aged < 2 years**. The decision to administer treatment in children under 2 years of age should be based on testing and clinical judgement.

- *Strong recommendation*
- *Certainty of evidence: moderate*



Implementation guidance:

Preventive chemotherapy in preschool-aged children (pre-SAC) is appropriate for those aged ≥ 2 years. Younger children, aged < 2 years, may be considered for treatment on an individual clinical basis.

The medication for Pre-SAC should be *an oral disintegrating tablet formulation* that is easily administered, disintegrates in the mouth and, ideally, has a sweet taste and smell; if paediatric formulations are not available, praziquantel crushed in soft food may be used for individual case treatment only.

Country	PSAC
Angola	1,803,888
Burundi	120,288
Benin	358,038
Burkina Faso	81,730
CAR	422,576
Côte D'Ivoire	668,922
Cameroun	257,490
DRC	1,378,826
Congo	7,735
Ethiopia	818,631
Gabon	141,671
Guinea	408,430
Guinée-Bissau	65,619
Madagascar	281,788
Mali	1,633,013
Mauritanie	61,824
Niger	707,339
Sénégal	641,260
Chad	310,193
Togo	77,316
Botswana	9,962
Eritrea	73,285
The Gambia	56,907
Kenya	1,044,085
Liberia	246,289
Mozambique	1,809,058
Malawi	1,018,996
Namibia	58,641
Nigeria	4,465,210
Rwanda	334,944
Sierra Leone	149,485
South Sudan	331,923
Eswatini	52,622
Tanzania (Mainland)	2,921,967
Tanzania (Zanzibar)	49,388
Uganda	590,637
South Africa	32,518
Zambia	532,797
Zimbabwe	118,546
Total	24,143,837

PSAC Population requiring treatment in the Africa region

Total PSAC	Population requiring preventive chemotherapy	Population requiring preventive chemotherapy in low endemicity units only	Population requiring preventive chemotherapy in units due for impact assessment	Population requiring preventive chemotherapy in urban units only	Population requiring preventive chemotherapy in urban units only
24,143,837	6,896,116		5,776,095	5,776,095	956,718

Highest burden Countries:

Nigeria (4.5m),
Tanzania Mainland (2.9m),
Angola (1.8M),
Mozambique (1.8m),
DRC (1.4 m)
Mali (1.6m),
Kenya (1m),
Malawi (1m)



SCH Morbidity in Children in Uganda

Pediatric Drug Optimization (PADO) Priority list

Schistosomiasis

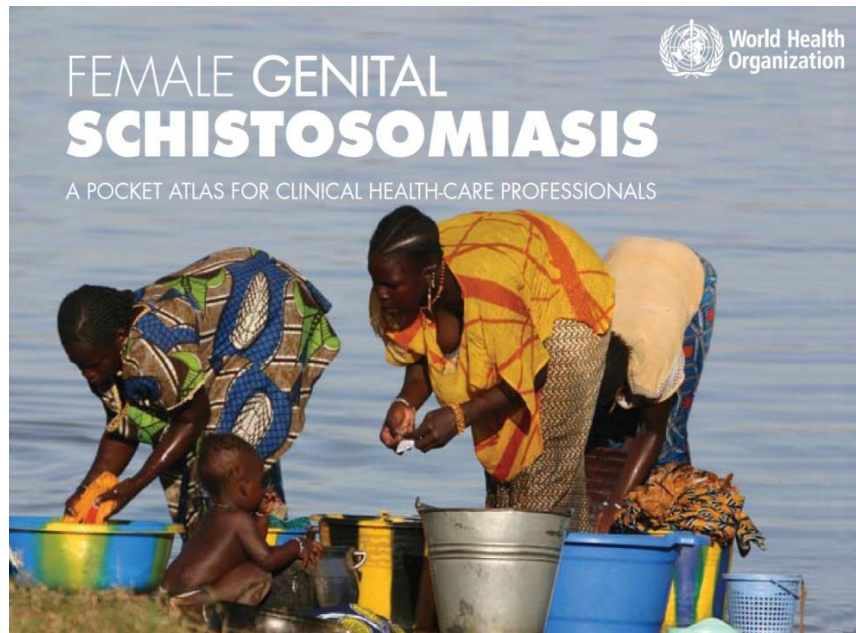
L-praziquantel 150 mg ODT	L-praziquantel 300 mg scored ODT
• EMA has given positive scientific opinion for children 3m-6y • Clinical development programme well underway, it provides the fastest route to a child-friendly formulation of PZQ • To be prioritized and supported for uptake and implementation by country programmes	• Reduces pill burden, improves acceptability (considering min dose requirement: 300 mg) • Functional scoring line to enhance dose flexibility for MDA for schisto, but also considering that it could be used for other indications (eg, taeniasis), which require 150 mg dose increments.

Dose
**Child weighing 15 kg:
5x150 mg ODTs for MDA**

*Discussions ongoing to explore the
feasibility of developing this formulation
from a CMC point of view*

Female Genital Schistosomiasis (FGS) is a health condition occurring in a parasitic disease caused by *Schistosoma* worms, affecting the female genital tract and leading to lesions, pain, and reproductive health issues, and predisposing WRA to HIV and Cervical Cancer

FGS capacity-building material for clinical health care staff



FEMALE GENITAL SCHISTOSOMIASIS



For women and girls who present with urogenital symptoms and who have had contact with fresh water in countries endemic for schistosomiasis, the diagnosis of female genital schistosomiasis (FGS) must be considered.

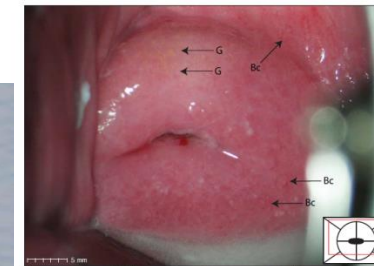
FGS is diagnosed by visual inspection of characteristic lesions on the cervix and vaginal wall. Visualization can be improved by using a digital camera or a colposcope. Current laboratory techniques are inadequate for diagnosing FGS. If one FGS case is seen, there are probably many others in the same area. All who have used the same source of water are at risk. It is especially important to identify children who may have early schistosomiasis.

The WHO-recommended treatment for schistosomiasis is PRAZIQUANTEL 40 MG/KG AS A SINGLE DOSE.

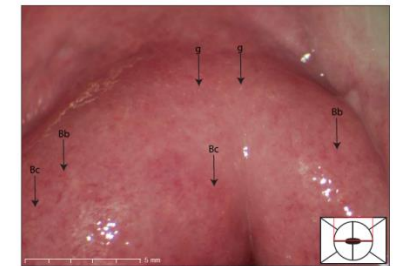
Regular treatment with praziquantel during preventive chemotherapy activities (mass drug administration) to communities and schools in endemic areas is an important public health intervention against FGS. Dosage is determined by measuring height using a dose pole.

Treatment kills the adult worms and prevents new FGS lesions.

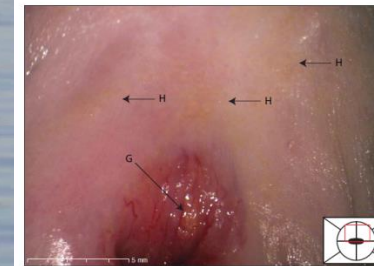
For further information and examples on FGS, please refer to the WHO Female Genital Schistosomiasis Pocket Atlas (2015).



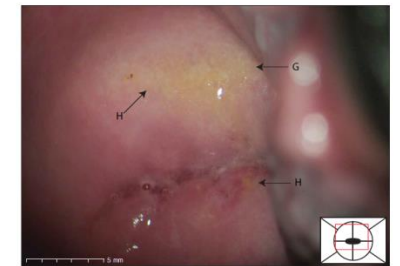
Granular sandy patches (G). Widespread abnormal blood vessels: circular (Bc). The discharge shown is candidiasis.



Sandy patch appearing as single grains (G). Widespread abnormal blood vessels: circular (Bc) and branched (Bb).



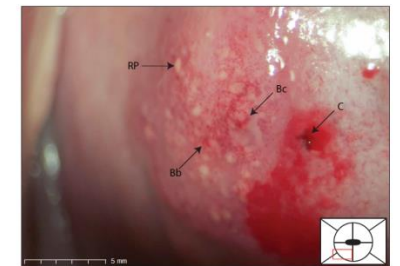
Homogenous yellow sandy patches (H). Granular sandy patches (G).



Homogenous yellow sandy patches (H). Granular sandy patches (G).

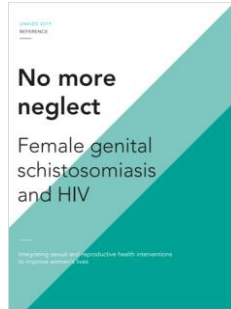
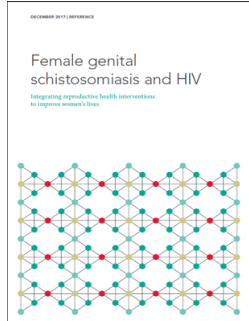


Widespread abnormal blood vessels: circular (Bc).

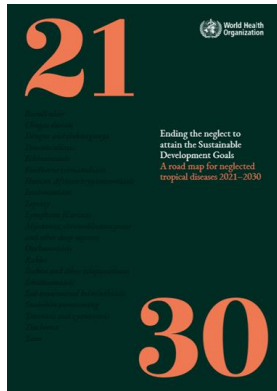


Rubbery papules (Rp). Abnormal blood vessels: circular (Bc) and branched (Bb). Contact bleeding (C).

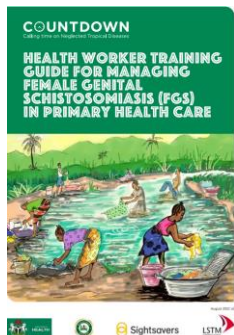
Current policy, guidance, advocacy, and current activities



- FGS is responsible for high mortality and morbidity in women
- Up to 56 million affected by FGS, nearly all in Africa

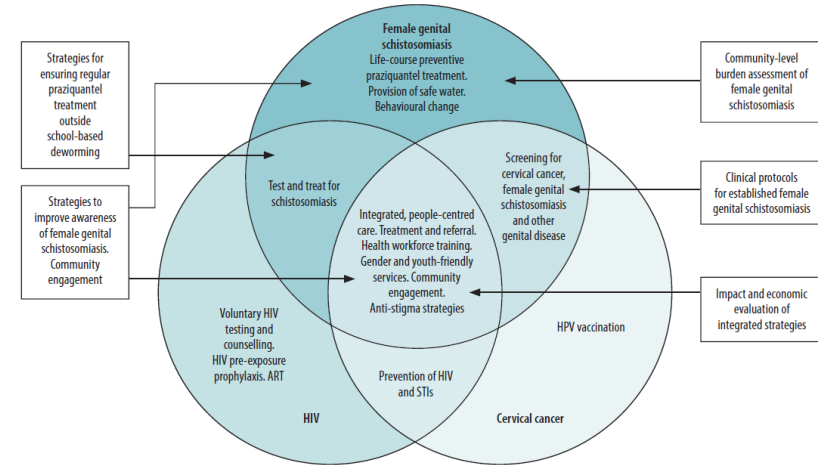


- Calls for integration among NTDs; mainstreaming into national health systems; coordination with relevant programmes for other diseases such as HIV, Child & Maternal health, etc; and strengthening delivery of interventions through country health systems
- Integration promotes a Sexual reproductive health rights-based gendered programme approach to FGS prevention and control



Current screening tools in use by research groups

Conceptual framework for the integrated programmatic implementation of female genital schistosomiasis, HIV and HPV/cervical cancer



ART: antiretroviral therapy; HIV: human immunodeficiency virus; HPV: human papilloma virus; STIs: sexually transmitted infections.

Dirk Engels et al. Integration of prevention and control measures for female genital schistosomiasis, HIV and cervical cancer. *Bull World Health Organ* 2020;98:615–624|doi: <http://dx.doi.org/10.2471/BLT.20.252270>



Bridges to development –countries reporting FGS activities 2021

- Countries that have developed FGS mapping survey protocols: Kenya, DRC, Madagascar, Guinea, Liberia, Togo, Burundi, C’ote D’Ivoire, Zambia, Mali Ghana, Ethiopia, Tanzania, Senegal
- Countries currently conducting FGS surveys: Tanzania -activity is underway
- Mali, Senegal, Ghana, Nigeria, and Madagascar to begin surveys in April-May.

Water, Sanitation and Hygiene activities (WASH) and Behaviour change interventions

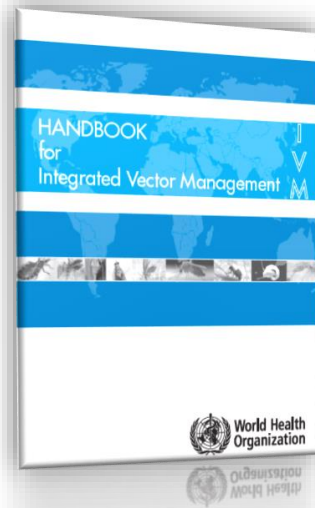
- WASH interventions essential for reducing transmission of *Schistosoma* spp.
 - Includes water access, sanitation, and behavioral changes
 - Implemented alongside preventive chemotherapy and health promotion
- Improved sanitation characterized by safe water sources and adequate waste disposal
 - Requires high resource utilization for infrastructure and maintenance
- WASH education critical for integrated control and elimination strategy
 - Maximizes health impacts through coordination and joint planning
 - Includes behavior change promotion within schistosomiasis/education/health programs

Snail control and environmental management



- Snail control measures can be implemented to combat schistosomiasis
 - Co-implementation with mass treatment campaigns and WASH interventions is essential
- Environmental management, drainage, and land reclamation can be used for snail control
 - Example: cleaning water canals to remove snail population
- Biological and chemical agents can also be used to reduce snail populations
 - Focal mollusciciding can be effective in specific situations
- Concerns about snail control and effects on the environment may vary
- Biological control via restoration of natural predators may also enhance schistosomiasis control
- Reduction of *Schistosoma* transmission via snail control is technically feasible in some settings

Control of infected snails in defined transmission areas



Resources:

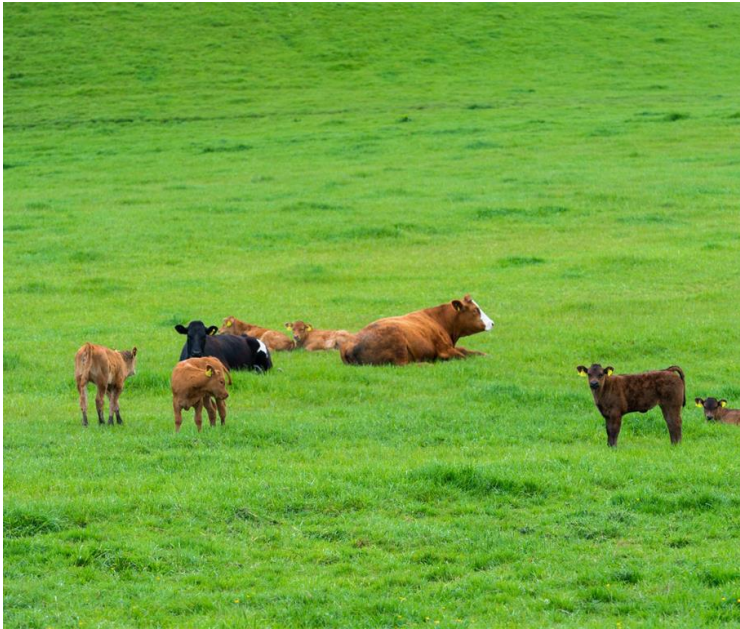
- Global Vector control response 2017-2030
- Handbook for Integrated Vector Management
- Field use of Molluscicides in Schistosomiasis Control Programmes: An Operational Manual for Programme Managers -2017
- Guidelines for laboratory and field testing of molluscicides for control of schistosomiasis -2019
- Generic risk assessment model for insecticides used for larviciding and mollusciciding, 2nd Edition -2018

<https://www.who.int/vector-control/publications/>

Major snail-control measures

	Methods	Specific snail-control measures
Ecological control	Agricultural measures	• Conversion of snail habitats to dry farms • Construction of fish ponds in low-elevation marshlands
	Water resource projects	• Cement lining of ditches and irrigation canals • Construction of snail sedimentation ponds to reduce water velocity and deposition of the snails
	Forestry projects	• Planting trees in high-elevation marshlands and lake areas
	Mechanical control	• Plastic film coverage for heat treatment
Chemical control	Molluscicide treatment	• Spraying, poudrage, immersion

Zoonotic schistosomiasis



- Schistosomiasis is a disease of veterinary importance
 - Can have major impacts on animal welfare, productivity, and socioeconomic factors
 - Jeopardizes livelihoods, food security, and nutrition of farmers' communities
- Control efforts have focused on eliminating the disease in humans
 - Limited attention paid to zoonotic schistosomiasis
 - Incidence of disease on animals
 - Role of farmed and wild animals as reservoir hosts
- 19 species reported to naturally infect animals
 - 10 species have received particular attention
 - Recognized veterinary significance for domestic ruminants in Asia and Africa
- Interspecific hybridization has been reported
 - Example: between *S. bovis* and *S. curassoni*

Hybrids of schistosomes

- Hybrids of livestock and human schistosomes are common in Africa and Europe
 - High prevalence of *S. haematobium*-*S. bovis* hybrids in humans associated with presence of *S. bovis* in local livestock
- Hybridization enhances capacity for human-to-human transmission
 - Basic reproduction number of *S. bovis*-*S. haematobium* hybrids in humans greater than 1
- Livestock reservoir of schistosomiasis could pose a threat to disease control
 - Hybrid parasites have increased host range and changes in host distribution
 - Hybridization may result in phenotypic characteristics that influence pathology and drug sensitivity
- Zoonotic transmission of schistosomiasis acknowledged by WHO
 - Gaps in scientific understanding and implementation of effective interventions

Morbidity of schistosomiasis in nonhuman animals



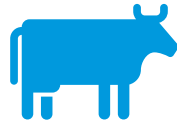
Adult worms found in the portal, mesenteric, and intestinal veins of the host

Eggs excreted through faeces and hatch in freshwater

Invasive suitable intermediate freshwater snail hosts

Cercariae leave snail and swim freely in water

Ruminants infected by penetration of skin or orally while drinking



Subclinical in cattle with high prevalence of low to moderate worm burdens

Chronic infections can cause significant losses on herd basis

Associated with diarrhoea, anaemia, weight loss, growth retardation, and severe eosinophilia



Nasal schistosomiasis caused by *S. nasale* characterized by cauliflower-like growths in nasal cavity



Occurrence of livestock schistosomiasis is discontinuous, depending on presence of intermediate snail hosts

Prevention of Zoonotic schistosomiasis

Treatment

- Praziquantel (PZQ), Except for nasal schistosomiasis, which requires anthiomaline
- PZQ administered orally or via intramuscular injection, curation effect can reach more than 99%
- Accurate understanding of body weight and adequate dosage are key
- PZQ dosages vary for different animal hosts
 - Cattle: 30 mg/kg, Buffalo: 25mg/kg, Sheep: 20mg/kg, Pig: 60mg/kg, Horse: 25 mg/kg
- For nasal schistosomiasis, treatment starts with anthiomaline injection
 - Can be repeated at weekly intervals until recovery
- Two treatments of PZQ may be required, case management or mass treatment.

Prevent contact between animals and parasite

- Water and sanitation improvements
- Prevent susceptible livestock from coming into contact with contaminated water bodies
- Provide clean water to animals and people via WASH interventions
- Replace ruminants with poultry or fish ponds in high-transmission areas

Destroy snail intermediate host population at transmission sites

- Chemical or biological methods
- Ecologic measures against snails

Large-scale bovine treatment using praziquantel

- Preventive chemotherapy alone is not sufficient
- Replace bovines with machines in farming

EPHP Readiness Analysis

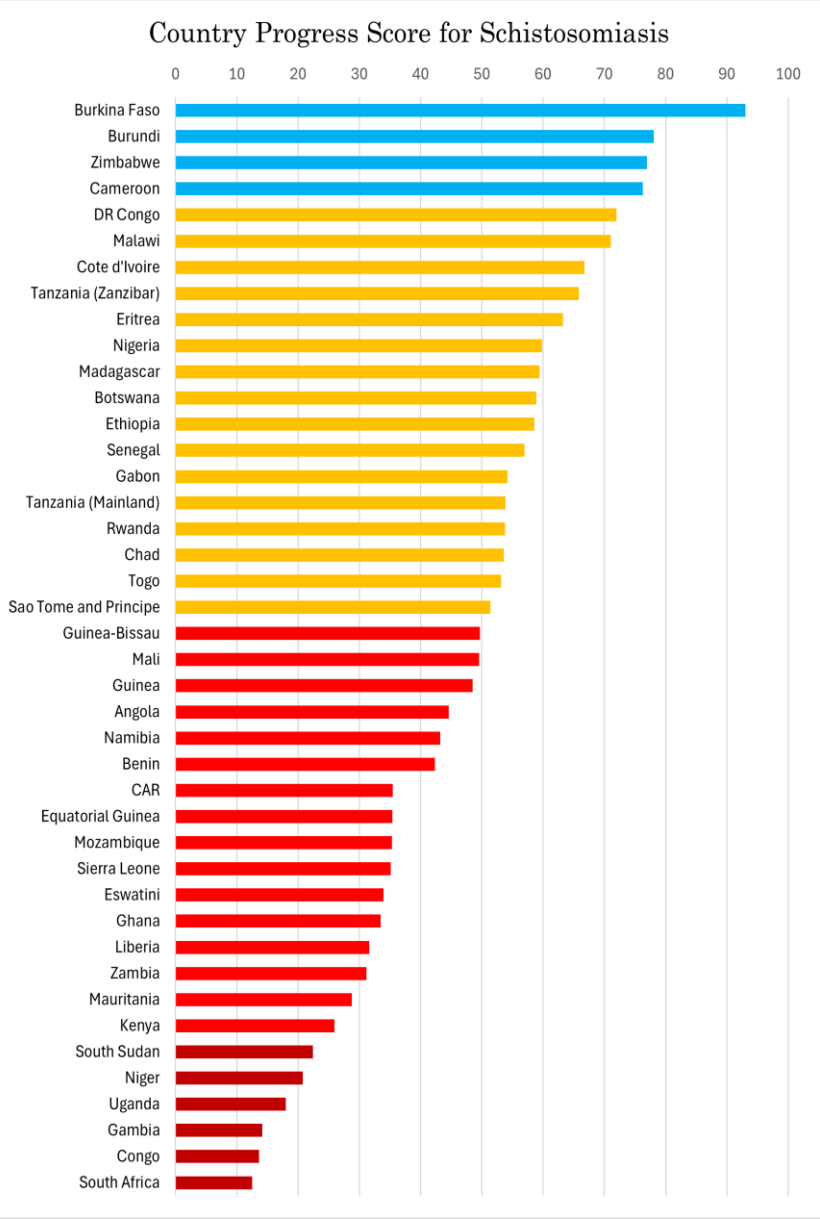
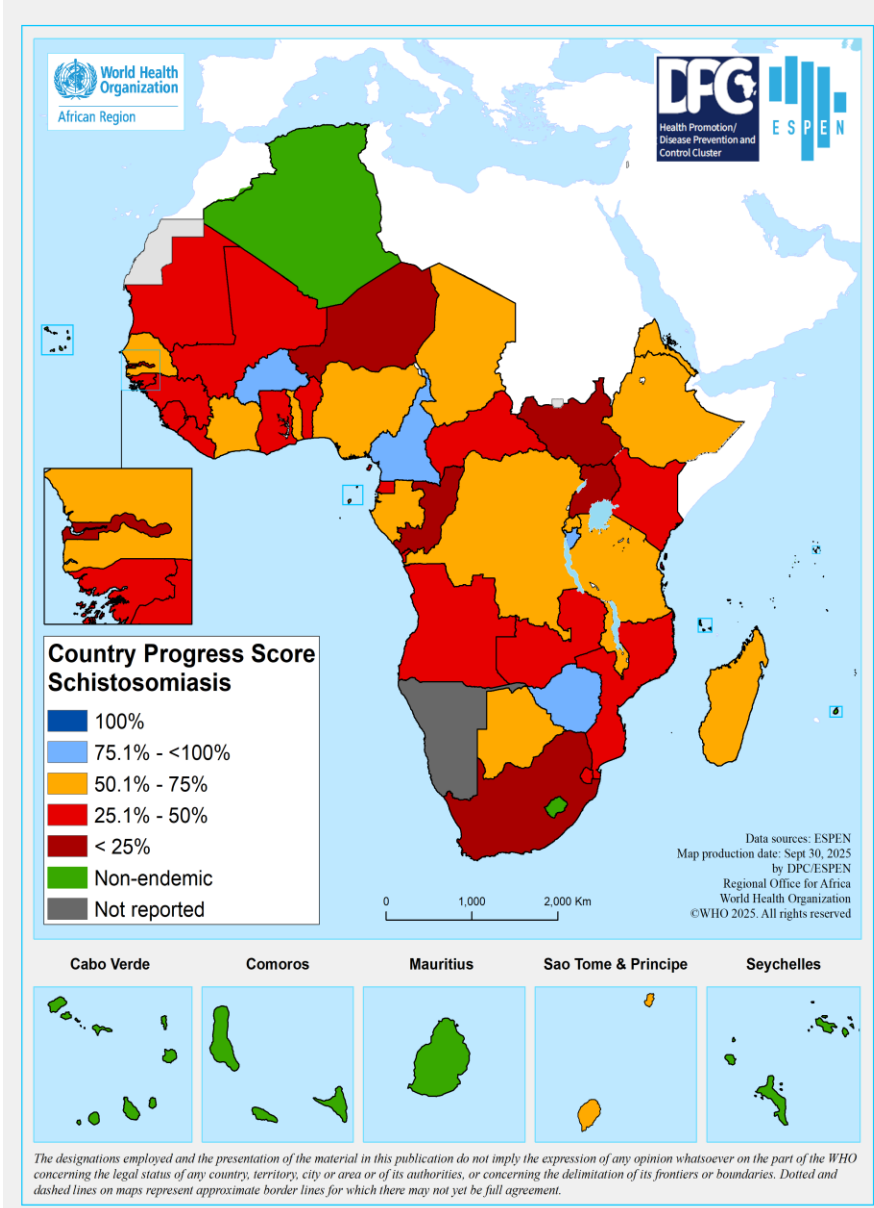
SCH –STH ePHP Heatmaps:



ESPEN composite score

- Aggregates multiple quantitative indicators, assigning different weights to reflect their relative importance.
- For SCH-STH, these indicators generally fall into the following categories:
 - Mapping Coverage (% of endemic areas mapped) – Ensures baseline knowledge of disease distribution.
 - MDA Implementation (% of endemic areas completing multiple MDA rounds) – Captures treatment reach and intensity.
 - MDA Stop Indicators (% of endemic areas under post-treatment surveillance or meeting elimination thresholds) – Evaluates progress toward stopping treatment.
 - Funding Availability (% of areas requiring MDA with secured funding) – Measures financial sustainability.
 - Additional Progress Indicators (varies by disease) – *to be included in future versions*

SCH Heatmap



EPHP Prevalence (<10% in all sub-IUs)

Country	<i>S. mansoni</i> prevalence range (%)	<i>S. haematobium</i> prevalence range (%)	Meets <10% in all IUs?
Benin	0.00 – 0.56	0.00 – 10.28	✓ Yes
Burkina Faso	0.00 – 0.69	0.00 – 11.05	✓ Yes (borderline ≤11%)
Ghana	0.00 – 0.63	0.00 – 10.28	✓ Yes
Kenya	0.00 – 40.45	0.00 – 28.03	✗ No
Malawi	0.49 – 17.56	4.32 – 20.22	✗ No
Mali	0.00 – 16.67	0.63 – 25.68	✗ No
Nigeria	0.00 – 0.00	3.33 – 3.33	✓ Yes
Senegal	0.00 – 1.35	0.21 – 35.19	✗ No
Tanzania (Mainland)	0.00 – 4.89	0.22 – 22.00	✗ No
Tanzania (Zanzibar)	–	0.00 – 3.96	✓ Yes
Togo	0.00 – 2.58	0.00 – 6.22	✓ Yes
Côte d'Ivoire	0.00 – 44.76	0.00 – 42.22	✗ No
Zimbabwe	0.00 – 70.37	0.00 – 26.72	✗ No
Guinea	46.14 – 88.12	0.83 – 12.71	✗ No

Countries meeting the <10% criterion across all implementation units (IUs):
Benin, Burkina Faso, Ghana, Nigeria, Tanzania (Zanzibar), and Togo

SCH EPHP Intensity (MI prevalence)

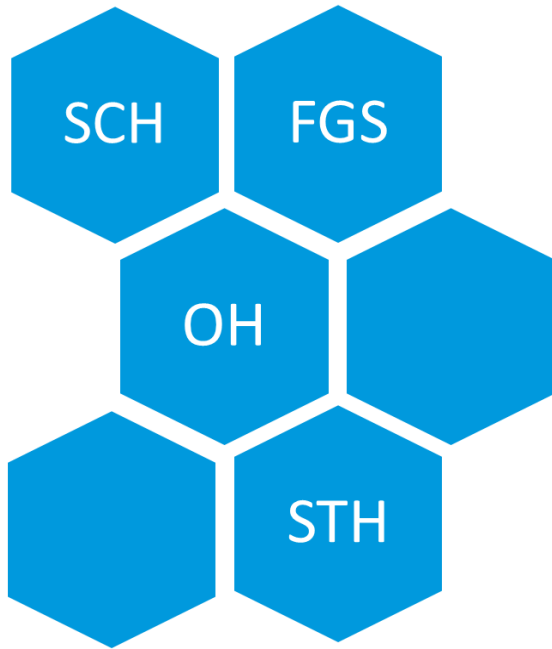
Country	<i>S. mansoni</i> (%; 95% CI)	<i>S. haematobium</i> (%; 95% CI)	IU Prevalence Range (Min–Max)	Meets <1% Criterion?
Benin	0.03 (0.00–1.20)	1.41 (0.82–2.45)	0.00–0.56 / 0.00–5.83	⚠ Borderline (>1%)
Burkina Faso	0.05 (0.01–0.18)	0.61 (0.36–1.03)	0.00–0.30 / 0.00–3.54	✅ Yes
Guinea	45.05 (38.27–53.04)	54.07 (47.18–61.96)	30.30–66.88 / 36.89–80.00	❌ No
Kenya	0.47 (0.38–0.57)	0.00 (0.00–0.01)	0.00–5.87 / 0.00–0.04	✅ Yes
Malawi	1.05 (0.28–3.90)	1.29 (0.58–2.96)	0.00–7.56 / 0.00–4.00	❌ No
Mali	0.66 (0.24–1.82)	2.61 (1.51–4.52)	0.00–16.67 / 0.00–8.33	❌ No
Senegal	0.07 (0.01–0.35)	2.58 (1.94–3.43)	0.00–0.83 / 0.00–11.76	❌ No
Tanzania (Mainland)	0.37 (0.13–1.08)	3.37 (2.36–4.80)	0.00–3.11 / 0.00–11.51	❌ No
Tanzania (Zanzibar)	–	0.60 (0.32–1.12)	– / 0.00–1.53	✅ Yes
Togo	0.22 (0.08–0.65)	0.67 (0.42–1.08)	0.00–1.58 / 0.00–2.88	✅ Yes
Zimbabwe	1.07 (0.62–1.83)	2.15 (1.58–2.92)	0.00–20.96 / 0.00–11.43	❌ No
Côte d’Ivoire	–	0.47 (0.26–0.88)	– / 0.00–17.32	✅ Yes
Ghana	–	–	–	✅ Yes (no heavy-intensity detected)
Nigeria (sub-national)	0	0	0.00–0.00 / 0.00–0.00	✅ Yes

EPHP Priority countries

Two Briefing webinars held in October 2025 to prepare the countries

Country ready or nearing readiness for EPHP Validation 2025	
Schistosomiasis	
1.	Algeria
2.	Mauritius
3.	Burkina Faso
4.	Tanzania (Zanzibar)
5.	Rwanda
6.	Togo
7.	Cote d'Ivoire
8.	Burundi
9.	Sao Tome and Principe
10.	Ghana
11.	Nigeria
12.	Malawi
13.	Eritrea

Amplifying the advocacy for Schistosomiasis among Member States of the WHO Region for Africa



The following draft documents have been developed for further inputs from the RPAG

- SCH Strategy 2026-2030
- SCH Strategy 2026-2030
- Genital schistosomiasis Strategy 2026-2030
- One Health for zNTDs 2026-2030

5. Advocacy for operational research and innovation

OPINION

Open Access



Priority knowledge gaps for schistosomiasis research and development in the World Health Organization Africa Region

Pauline N. Mwinzi^{1*} , Moses Chimbari², Khadime Sylla³, Maurice R. Odiere^{4,5}, Nicholas Midzi⁶, Eugene Ruberanziza⁷, Sylvian Mupoyi^{8,9}, Humphrey D. Mazigo¹⁰, Jean T. Coulibaly^{11,12}, Uwem Friday Ekpo^{13,14}, Moussa Sacko¹⁵, Sammy M. Njenga¹⁶, Louis-Albert Tchuem-Tchuente^{17,18,19}, Anouk N. Gouvras²⁰, David Rollinson²⁰, Amadou Garba²¹ and Elizabeth A. Juma¹

Abstract

Schistosomiasis, also known as bilharzia, is a widespread neglected tropical disease (NTD) in Africa, with more significant research and development (R&D) challenges and gaps compared to other preventive chemotherapy NTDs (PC-NTDs) like onchocerciasis, lymphatic filariasis, and trachoma. In response to this challenge, some global initiatives have advocated for bridging this gap, focusing on coordinated engagement with research donors. In this opinion article we highlight key R&D priorities for combating schistosomiasis in the WHO Africa region. These include defining morbidity indicators, expanding prevention, and developing innovative diagnostics, treatments, and public health strategies like test-and-treat. We emphasize integrating efforts with broader health campaigns, assessing zoonotic transmission through One Health, and using environmental surveillance tools like xenomonitoring and eDNA. We stress the need to study climate and environmental impacts on transmission, zoonotic transmission, schistosome hybridization, and snail ecology, advancing snail control, and developing vaccines, while calling for new treatments beyond praziquantel, addressing drug resistance, and improving access for children and remote populations. Further, operational research should refine hotspot interventions, enhance water, sanitation and hygiene integration, and address socio-cultural barriers. Lastly, sustainable funding and global collaboration are vital to achieve 2030 NTD Roadmap goals.

Keywords Schistosomiasis, Neglected tropical diseases, Preventive chemotherapy, One Health approach, Morbidity

Schistosomiasis Research and development knowledge gaps

- Preventive Chemotherapy
 - Focus on efficacy of Praziquantel and evaluation of country schistosomiasis strategies
 - Strategies to improve treatment compliance and implementation of new guidelines
- Diagnostics
 - Focus on new serologic methods and diagnostics for FGS
- Mapping
 - Community level mapping and identification of transmission in new areas
- Schistosomiasis Morbidity
 - Diagnostics and prevalence surveys for FGS, integration into health systems, and co-morbidities
- One Health Approach: Zoonotic control and hybridization research
- Intermediate Snail Host: Control measures
- Pediatric Formulation: Access and implementation

Issues and Challenges

Treatment and availability of praziquantel especially for adults, and access pediatric formulation for pre-school age children

Funding for implementation

Low coverage of adults for schistosomiasis PC in high endemic communities

Low implementation of cross-cutting strategies (WASH, snail control), experience of rebound after stopping MDA when appropriate WASH is not in place

Zoonosis and hybridization of the parasite

Availability of more sensitive diagnostic tests

SCH Strategic priorities

Scaling up impact assessment surveys in areas that have gone through more than 5 effective MDA rounds.

Continued improvement of community level data management, planning surveys, and reporting

Guidelines and protocols for post-MDA surveillance and strong surveillance systems to detect recrudescence and reintroduction.

Monitoring concomitance with taeniasis/cysticercosis, and animal reservoirs.

Clinical screening and morbidity management especially in adults, WRA

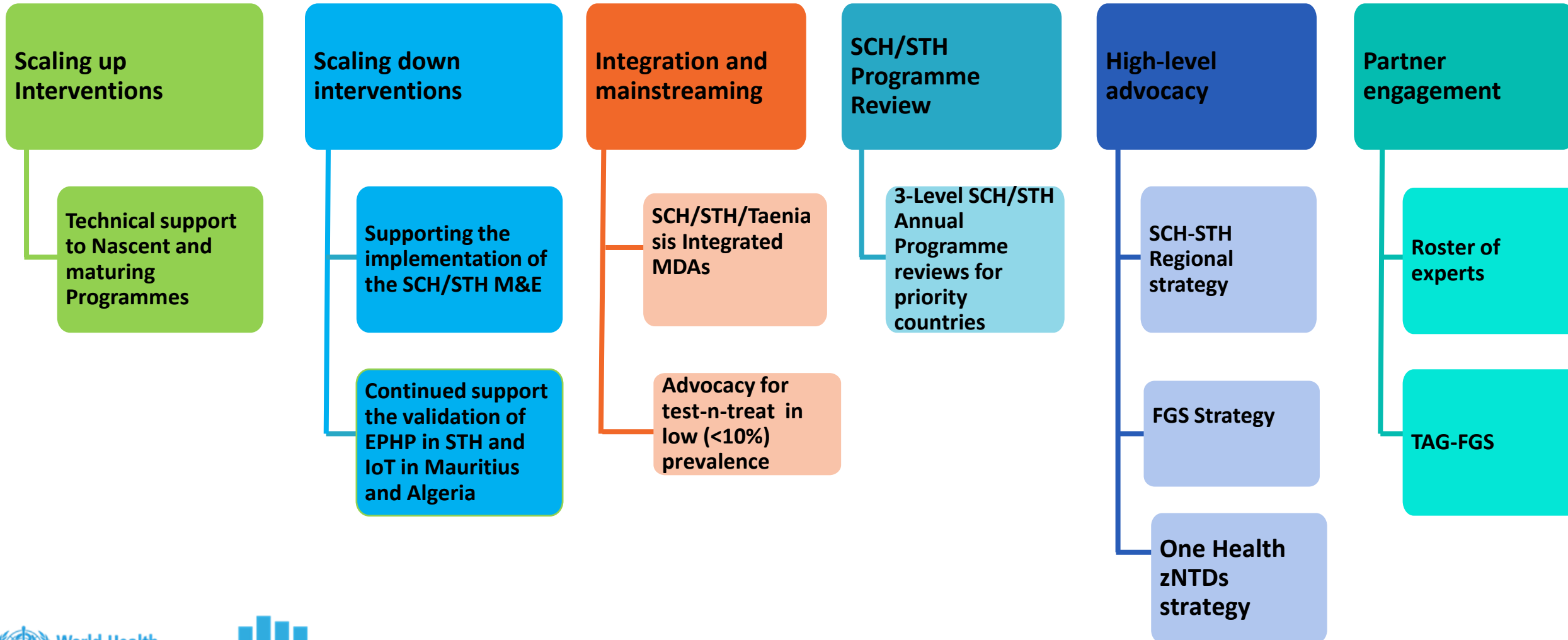
Scaling up screening for FGS and interventions among affected WRA

Delivering treatment to all target population according to updated WHO guidelines: all older than 2-yrs old.

Integrated approach to Elimination

- Preventive chemotherapy
- WASH
- Snail control and environmental

SCH/STH: Key priorities 2026-2027



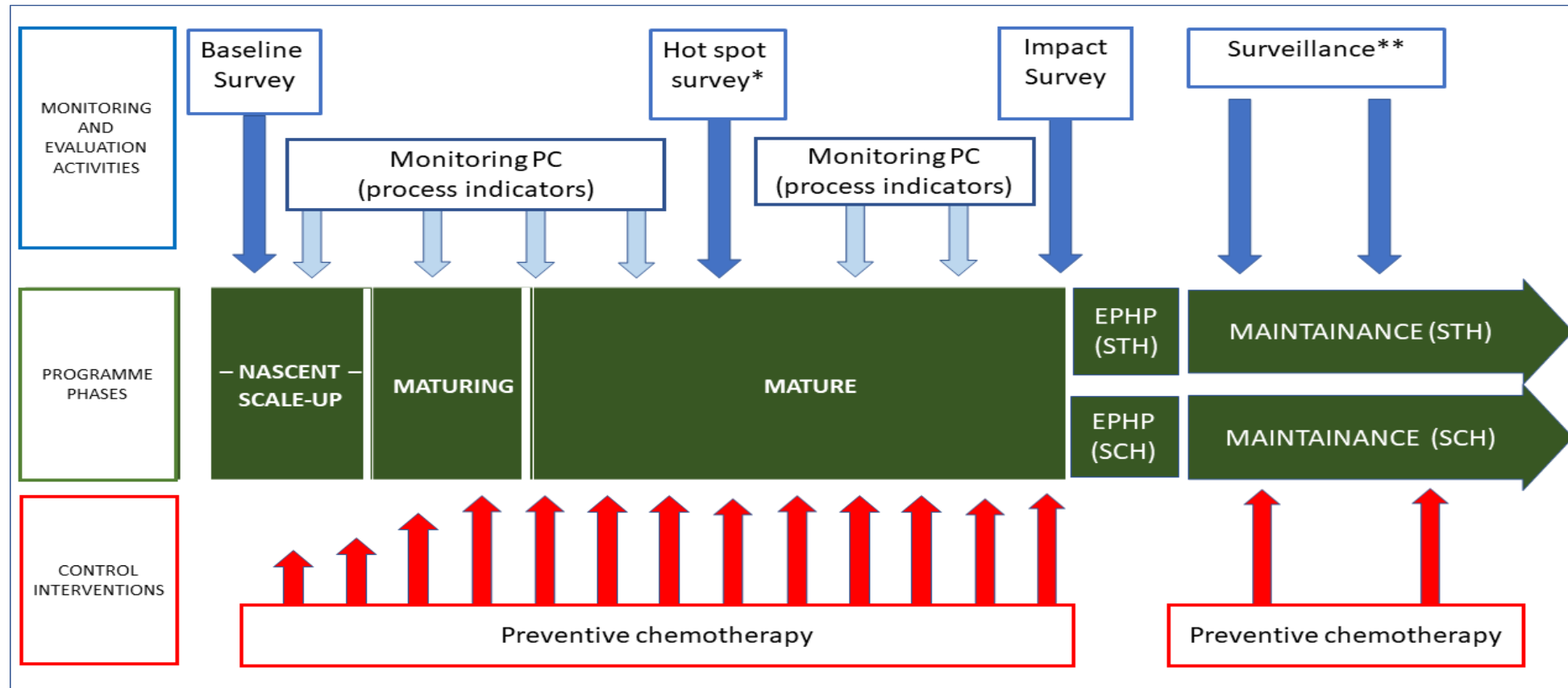
Funding gaps 2026 -2027

Intervention Area	Priority Countries	Estimated costs US \$
PC	Fully orphaned countries: Gambia, Lesotho, eSwatini, Eritrea, STP, Liberia, Burundi, South Africa (WCO), Congo, South Sudan and Zambia	2.5M
Impact assessments	Fully orphaned countries: Gambia, Lesotho, eSwatini, Eritrea, STP, Liberia, Congo, and Zambia.	2M
Case management and FGS	- Establish high-level national FGS committees priority countries with highest <i>S. haematobium</i> burden. - Strengthen country-specific FGS strategies and integrate into NTD master plans. - Conduct integrated operational research and interventions, including analysis of cervical cancer repositories and capacity building - Develop gender-sensitive approaches under the MMM: FGS awareness, screening, and interventions	2.7.5M
Support for rPZQ roll out	Support paediatric PZQ rollout through data management support	500
TOTAL		7.5M

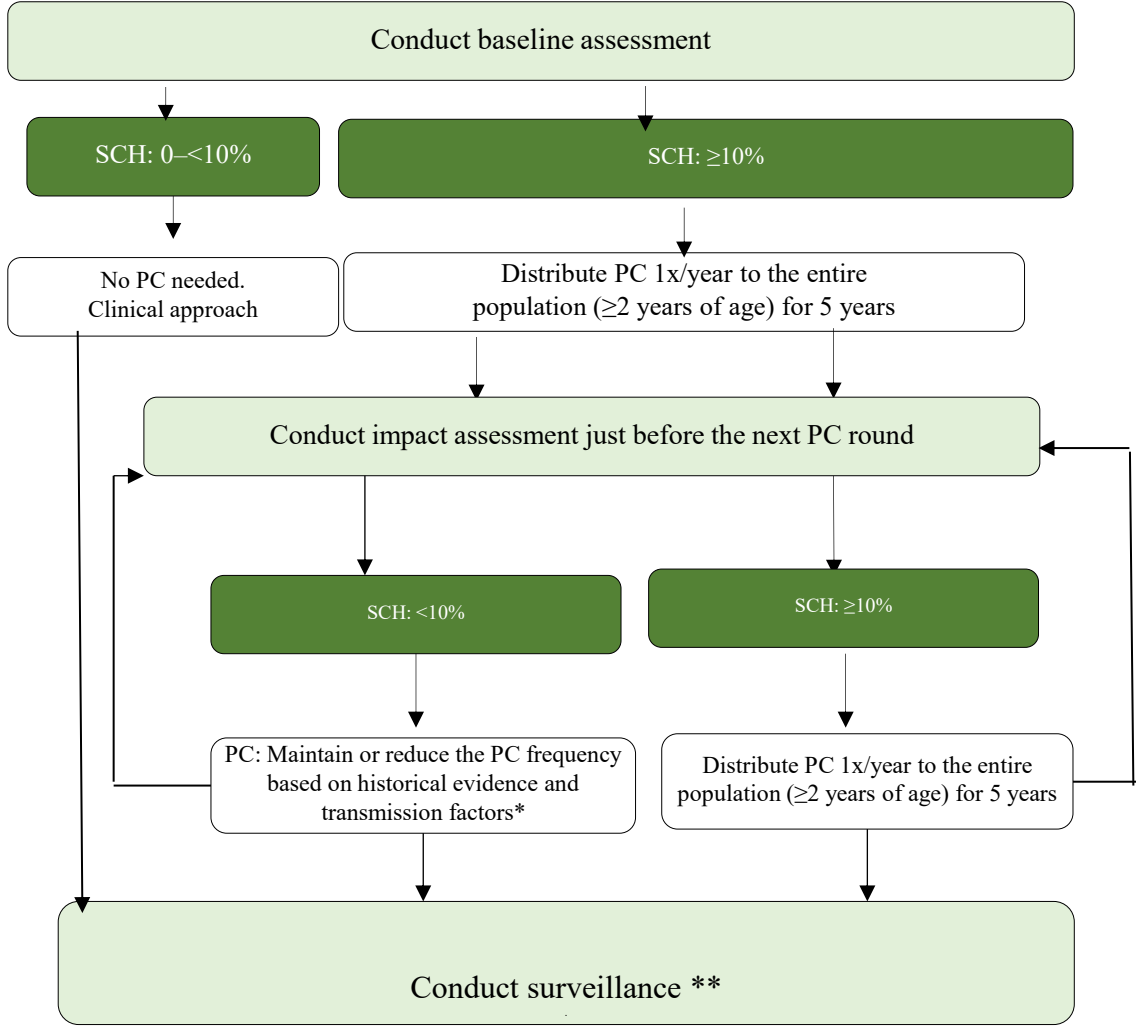
Thank you



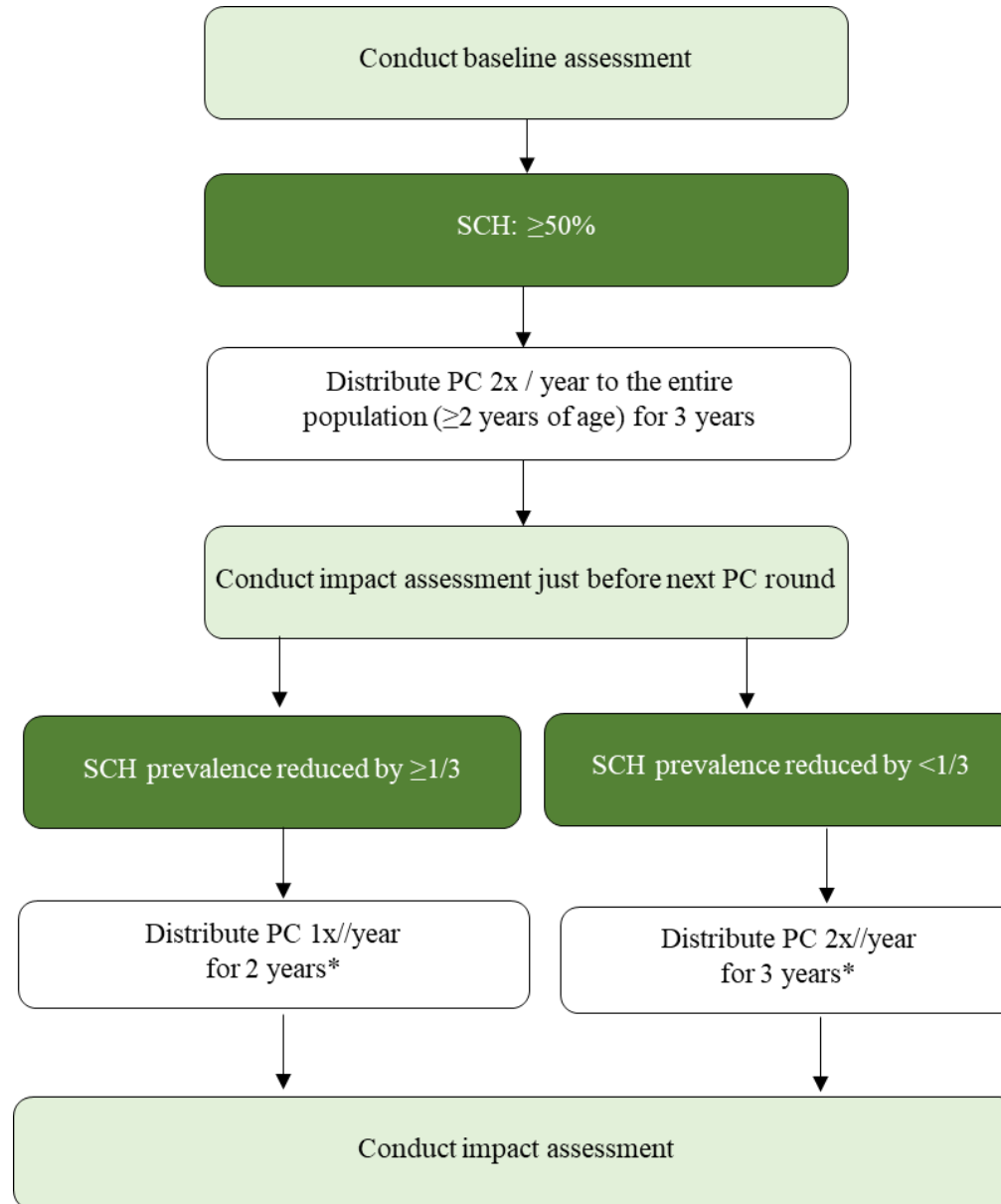
SCH –STH M&E Framework



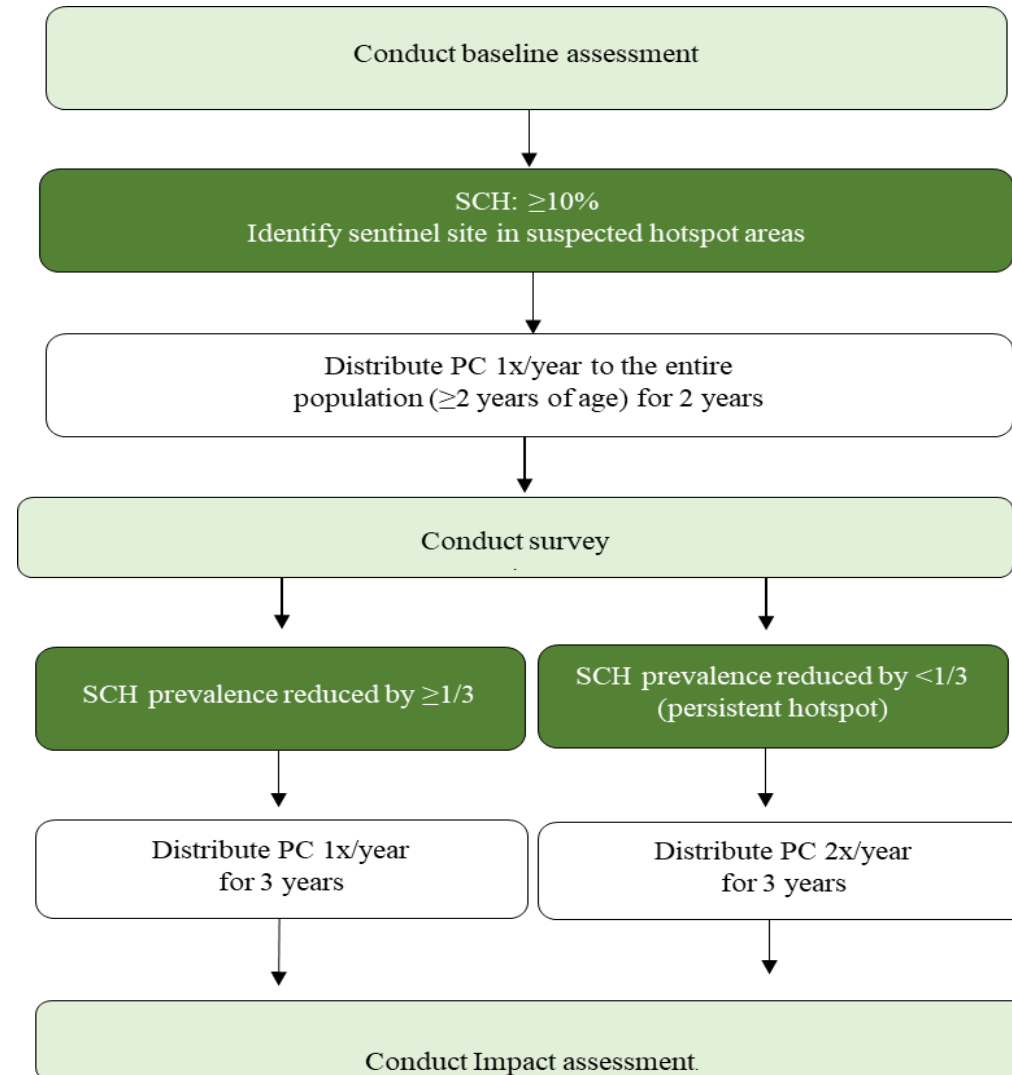
Standard approach



Special case 1. High prevalence areas ($P \geq 50\%$)



Special case 2. Hot spots



•THANK
•YOU



DFPC

Health Promotion,
Disease Prevention and
Control Cluster



E S P E N

EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING

NTD Data Use, Reporting and Supply Chain Capacity

Kintélé, Brazzaville,
Republic of the Congo

Update on recent developments in Human Onchocerciasis and Lymphatic filariasis

Didier Bakajika, Medical officer LF/Oncho



Health Promotion,
Disease Prevention and
Control Cluster



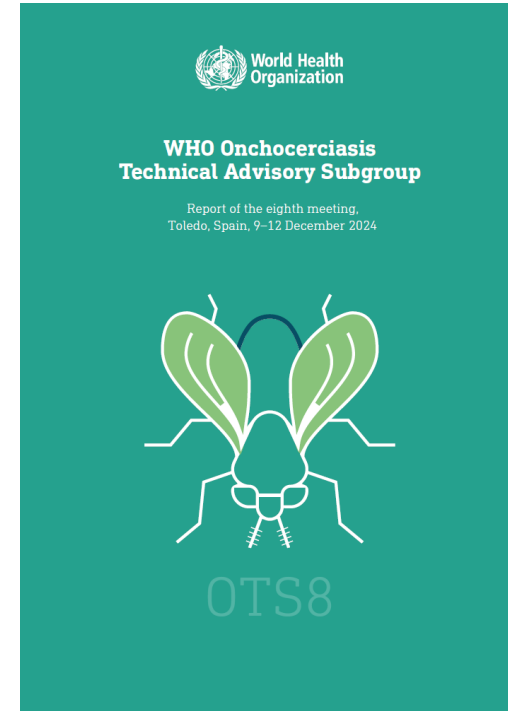
EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



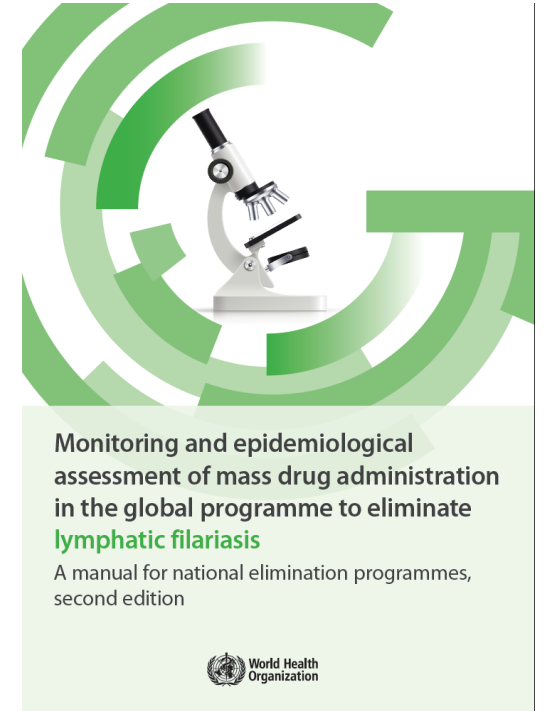
Training workshop on effective PC-NTDs data processing and use for English-speaking countries

Update on recent developments in Human Onchocerciasis and Lymphatic filariasis

Kintélé • 24–28 August 2026



OTS8 report (2024)



M&E manual — LF (2nd ed.)

Outline

1 **Human onchocerciasis**

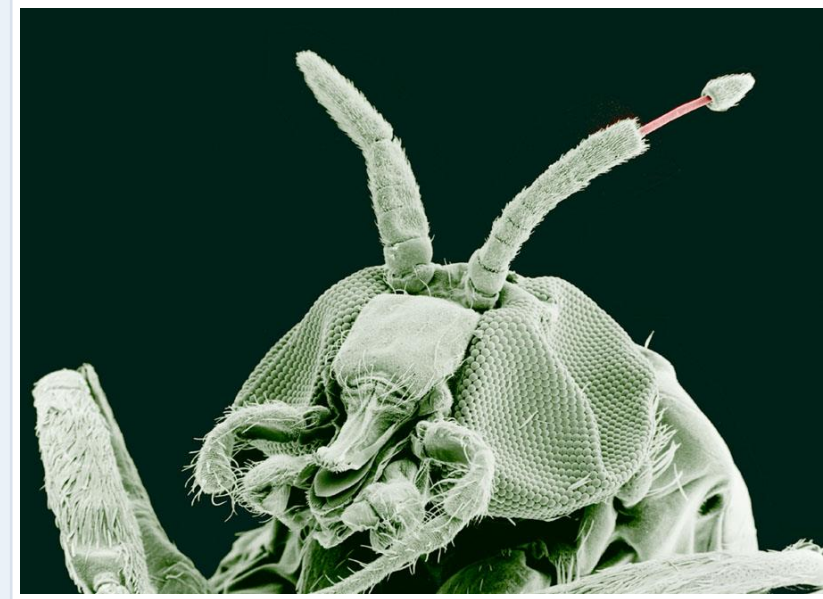
2 **Lymphatic filariasis**

3 **Integrated post-validation (LF) or post-verification (Oncho) surveillance**

Human onchocerciasis



Blackfly (Simulium spp.) — vector of onchocerciasis



Onchocerca volvulus emerging from a blackfly

Images: public domain (Wikimedia Commons / CDC).

Routine monitoring and evaluation surveys

2017 guidance – OTS7

- Timing: every 3–5 years
- Target: children aged 5–9 years
- Coverage survey (supervisor's coverage tool) and treatment adherence
- Identification of larval breeding sites and selection of first-line communities without confirmation by prospection

OTS8 (December 2024)

- Unchanged
- Unchanged
- **Unchanged. Do not replace serological and entomological surveys with routine monitoring and evaluation surveys**
- **Larval breeding sites must be determined based on their productivity, after prospection surveys**

Pre-stop-treatment surveys

2017 guidance – OTS7

- Target: children aged 5–9 years
- Evaluation unit: district or TZ
- Number of villages: at least 3–5 first-line villages
- Treatment coverage: denominator not specified
- Number of treatment rounds and years
- Decision threshold: ≤ 2 positive children, number of villages not specified

OTS8

- Unchanged
- Unchanged
- Unchanged
- **Coverage: 65% with the total population as denominator**
- **Number of treatment years (≥ 12 years)**
- **Decision threshold: ≤ 2 positive children in each surveyed villages**

Stop-treatment surveys

2017 guidance – OTS7

- TZ size: not specified
- Representativeness of breeding sites and children within the TZ: not mentioned
- Sample size / serology: at least 3,000 children
- Sample size / entomology: at least 6,000 / TZ
- Larval breeding-site productivity: not specified

OTS8

- TZ size: to be specified in future
- **Representativeness of breeding sites and children: very important**
- **Sample size / serology: to be adjusted according to EU size**
- **Sample size / entomology: to be adjusted according to TZ size**
- **Larval breeding-site productivity: critical**

Post-treatment surveillance (PTS)

2017 guidance – OTS7

- Duration: 3–5 years
- Start: after stopping MDA (IVM)
- LF and Oncho integration: not mentioned
- Start of entomology: not specified

OTS8

- Duration: unchanged
- Start: unchanged
- **LF and Oncho integration: integrate LF – TAS & PTS**
- **Start of entomology: at least in year 3; flexibility to start early in countries at high risk of recrudescence**

Lymphatic filariasis



Culex quinquefasciatus — vector of lymphatic filariasis



Wuchereria bancrofti microfilaria

Images: public domain (Wikimedia Commons / CDC).

Lymphatic filariasis: mapping, epidemiological monitoring survey, and TAS/IIS

Mapping

- Confirmatory mapping
- Community- or school-based
- Children 9-14 years

Epidemiological monitoring survey

- Age: 20+ years
- Rapid test + nocturnal calibrated thick smear (NCTS)
- Rapid test: 1% threshold regardless of vector
- Parasitology: < 1% (NCTS)

TAS / IIS

- Evaluation unit : max size 500,000
- Critical cut-off: 1–6 (SSB)
- Treatment: according to the distribution of positives within the cluster / EU and available resources
- TAS2 / IIS2: not mandatory (interim measure in the current context)



Integrated post-validation and post-verification surveillance for Neglected Tropical Diseases (NTDs)

A planning toolkit

Integrated surveillance begins once elimination has been validated (LF) or verified (Oncho), to detect any residual transmission or recrudescence.

Ref.: Integrated post-validation and post-verification surveillance for neglected tropical diseases: a planning toolkit. Geneva: WHO; 2026.

1

Health-facility screening

Platform 1 of 4 · Integrated post-validation surveillance (PVS – Oncho/LF)

- Patients ≥ 5 years attending the OPD — co-integrated with malaria diagnosis
- Biomarker: nocturnal microfilaraemia (thick smear, 22:00–02:00) and RDT (FTS or QFAT)
- Priority target: children 5–9 years (post-validation sentinel group)
- Minimal marginal cost — existing infrastructure, staff and supplies
- Trained technicians reading LF and malaria simultaneously

Source: WHO M&E manual for LF, 2nd ed. (2025) · Planning toolkit (WHO, 2026). Combine at least 2 of the 4 platforms.

2

Existing standardized surveys

Platform 2 of 4 · Integrated post-validation surveillance (PVS – Oncho/LF)

- Periodic representative surveys of defined populations
- Integrates into existing national surveys (MICS, DHS, etc.)
- Can target specific age groups and geographic areas
- Requires dedicated planning and additional resources
- Complements passive surveillance by reaching populations absent from the OPD

Source: WHO M&E manual for LF, 2nd ed. (2025) · Planning toolkit (WHO, 2026). Combine at least 2 of the 4 platforms.

3

Molecular xenomonitoring

Platform 3 of 4 · Integrated post-validation surveillance (PVS – Oncho/LF)

- Detects *W. bancrofti* DNA in vector mosquitoes (*An. gambiae* · *Cx. quinquefasciatus*)
- High sensitivity: detects active transmission before human cases appear
- Method: CDC light traps → sorting by species → LAMP on pools → PCR confirmation
- A positive result is direct evidence of ongoing vector-borne transmission
- Fills geographic gaps where human surveillance is insufficient

Source: WHO M&E manual for LF, 2nd ed. (2025) · Planning toolkit (WHO, 2026). Combine at least 2 of the 4 platforms.

4

Surveys targeting at-risk areas / groups

Platform 4 of 4 · Integrated post-validation surveillance (PVS – Oncho/LF)

- Populations excluded from the passive system: migrants, nomads, refugees, border communities
- Areas adjacent to countries still endemic for LF
- Biomarker: RDT / FTS or QFAT (circulating antigen) → microfilaraemia confirmation if positive
- Only platform reaching groups not covered by MDA
- Complementary to the other platforms — eliminates blind spots

Source: WHO M&E manual for LF, 2nd ed. (2025) · Planning toolkit (WHO, 2026). Combine at least 2 of the 4 platforms.

Thank you for your attention



•THANK
•YOU



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TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING

NTD Data Use, Reporting and Supply Chain Capacity

Kintélé, Brazzaville,
Republic of the Congo

Supply Chain Management for PC-NTDs

Namuchile Kaonga, Supply Chain Management Officer



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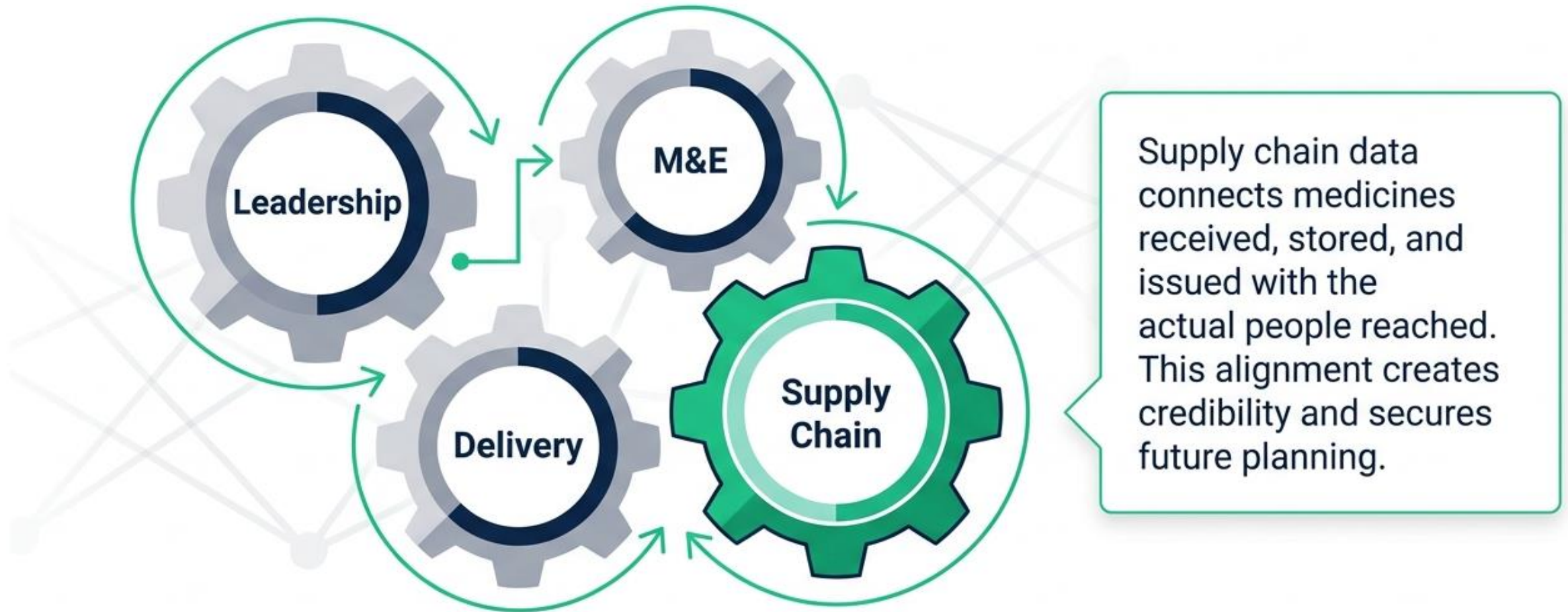


Supply Chain Management for PC-NTDs

Reliable data, accountable medicines,
and programme reporting.

A shared management conversation on data foundations.

Programme results depend on integrated systemic functions



Creating a clear management line of sight from medicines to results

1

What entered?

(Receipts & approved transfers)

2

What moved?

(Issues, distribution & returns)

3

What was used?

(Treatment & consumption)

4

What remains?

(Verified physical balance)

When these four answers align, programmes can report with confidence and act early on gaps.

The External Threat: Geopolitical Supply Bottlenecks

Extended procurement and transit lead times have fundamentally altered global delivery schedules.



Little Margin for Error:

Early and accurate applications are now an absolute necessity. Late or disputed submissions can lead to stockouts.

The Internal Threat: The Unaccounted Gap



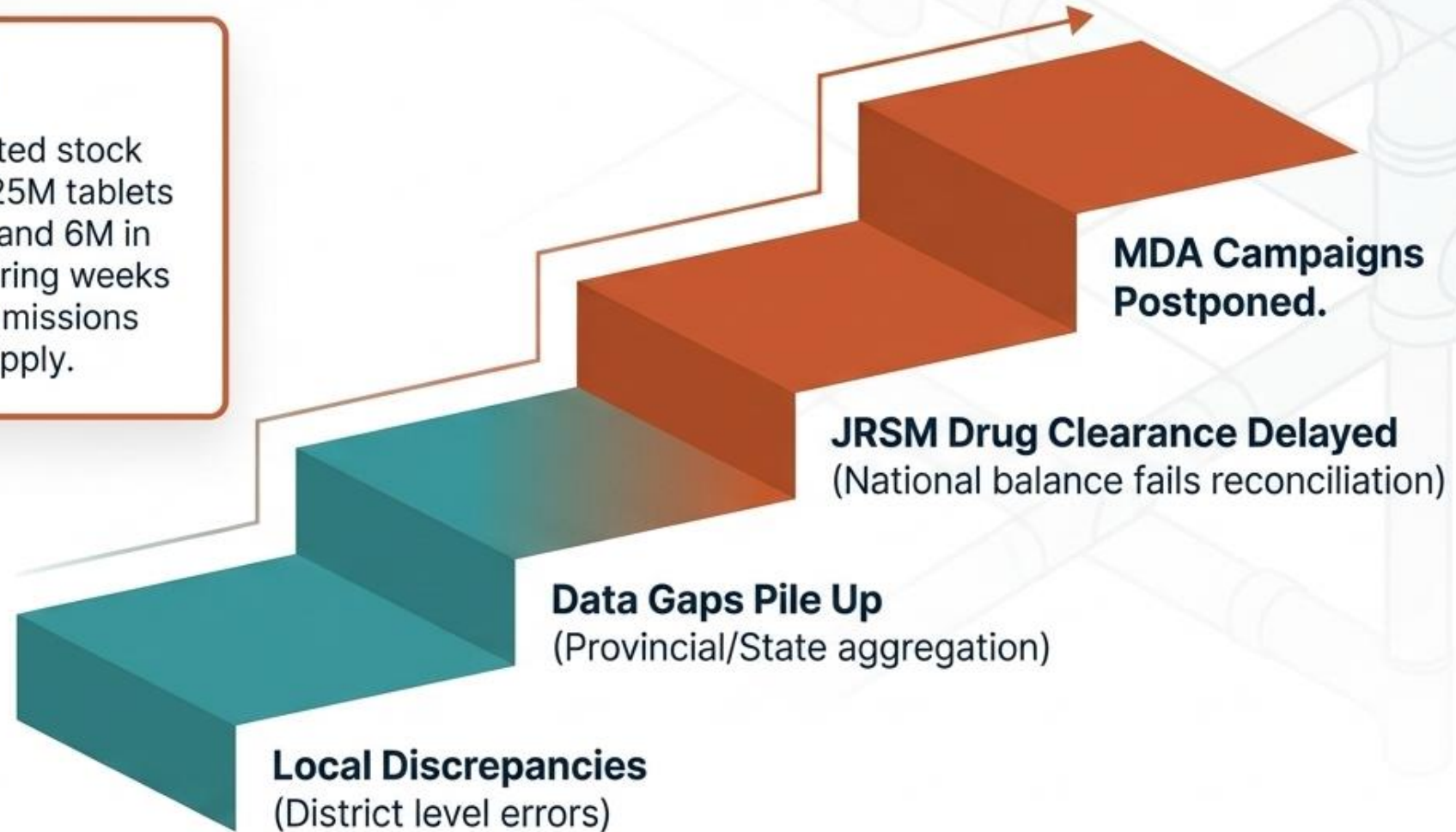
Root Cause: When treatment and inventory data are collected independently, invisible discrepancies pile up.

The Rule: A discrepancy remains unaccounted—and halts the pipeline—until traced, corrected, or validated.

How local data gaps paralyze national campaigns

! Reality Check

Audits show unaccounted stock delays reaching up to 25M tablets in one African country and 6M in an Asian country, requiring weeks of emergency retrieval missions just to unlock future supply.



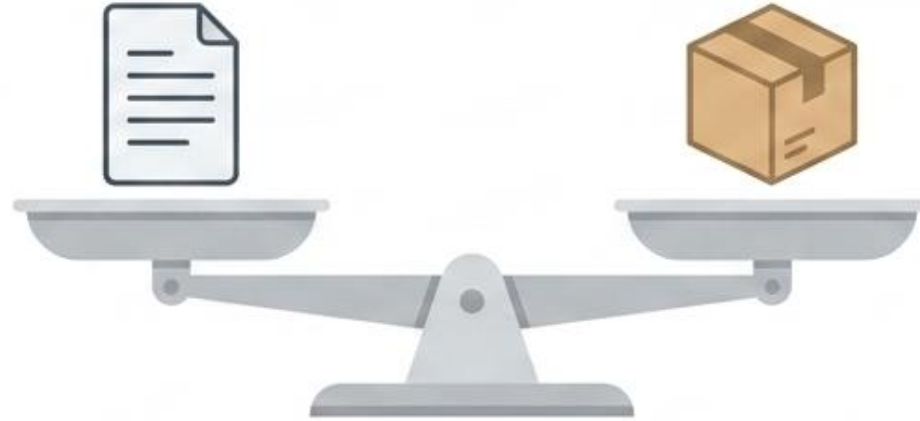
The First Defense: Line-by-Line Integration

Health Facility A						
Opening	Received	People Treated	Tablets Used	Losses	Physical Balance	GAP
1,000	9,000	7,000	7,000	50	2,500	450

By putting treatment totals and physical stock on the same reporting line, local officers instantly spot and resolve discrepancies before the data moves upward.

The Foundation of Accuracy: Inventory Reconciliation

Theoretical Balance =
(Available + Received -
Distributed - Wasted)



Physical Balance =
Counted Stock

**This Year's
Remaining Balance**

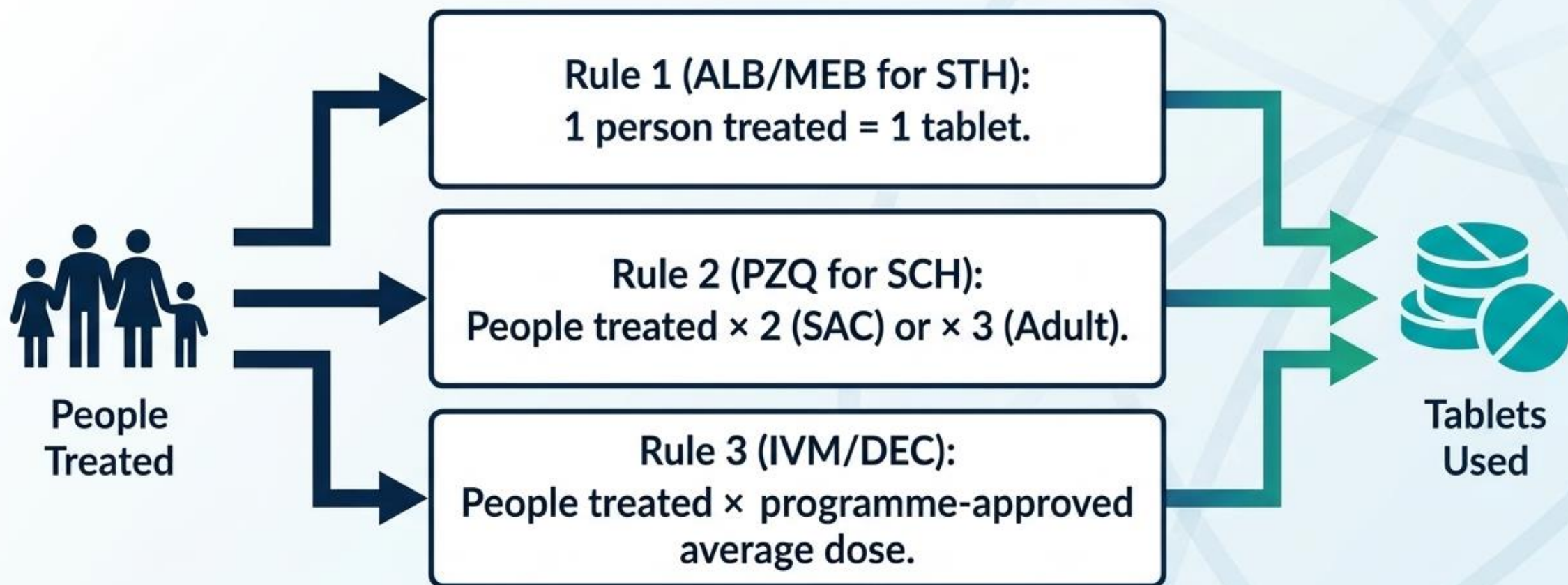
Errors carry forward perpetually.

**Next Year's
Opening Available**



Balances must be reported
exactly as of December 31st.

Conversion Rules: Reconciling People and Pills



Donors account for **donated medicines** in tablets, not just in the number of people reported as treated.

Reporting and Forecasting are Two Halves of the Same Cycle



Navigating the JRF: The Accountability Record

The JRF Excel file
standardizes reporting.

The SUMMARY sheet
aggregates all data.

This sheet **MUST** be
printed, signed, and
submitted as the final
joint report.

Coverage
Validation



PC Joint Reporting Form v.4.2

The purpose of this template Joint Reporting Form (JRF) - available as an Excel file - is to provide national health authorities and data managers with a standardized tool to address these reporting challenges, facilitate integration and thereby further contribute to improving overall programme management. This template aims to standardize national reporting of programme implementation outcomes, improve availability and coordination of preventive chemotherapy data across the World Health Organization regions.

INTRO

COUNTRY_INFO

MDA1

DISTRICT

SUMMARY

World Health Organization within 3 months after the last round was implemented and no later than 31 March of the next implementation year.

PC Joint Reporting Form v.4.2 (Loa)

Country: **Motanga** Year: **2023**

National authorities are requested to complete the Joint Reporting Form (JRF) for submission to the World Health Organization within 3 months after the last round was implemented and no later than 31 March of the next implementation year.

Number of people received treatment (at least once) for the diseases (all areas) and geographical coverage (%)

	PreSAC	SAO	Adults	Total	Geographical
Lymphatic filariasis		817,076	1,487,776	2,304,848	100.00
Onchocerciasis	Not eligible	979,077	1,784,332	2,743,319	100.00
Soil-transmitted helminthiasis		913,321	1,487,716	2,491,197	100.00
Schistosomiasis		887,333		887,341	75.60

Number of people in need (in areas requiring PC) received treatment for the diseases and national coverage (%)

	PreSAC	SAO	Adults	Total	National
Lymphatic filariasis				1,368,659	37.23
Onchocerciasis	Not eligible	979,077	1,784,335	2,743,315	85.59
Soil-transmitted helminthiasis		485,129	416,769	874,908	65.59
Schistosomiasis		813,842		813,642	15.06

Number of people treated by PC intervention and programme coverage (%)

	PreSAC	SAO	Adults	Total	Programme
MDA 1 (IVM+ALB)	Not eligible	817,076	1,487,776	2,304,846	53.19
MDA 3 (IVM)	Not eligible	161,599	277,565	439,064	53.24
MDA 4 (ALBIZ/ALR)					
T 1 (P2Q+ALB/MBD)	Not targeted	485,777	Not targeted	488,773	24.45
T 2 (P2Q)		396,671		396,671	30.65
T 3 (ALB/MBD) - round 1		22,402		22,402	8.55
T 3 (ALB/MBD) - round 2					

Inventory of PC medicines in the country

	IVM	DEC	ALB (LF)	ALB (STH)	MBD	P2Q
Available						
Distributed						
Wasted						
Received						
Reordering						

Please indicate the medicine has been used to treat PreSAC for STH and delivery channels

PC medicine	Delivery channels	Source
Source		

Joint reporting form and information about

the structure of the country, population by location requiring PC, planned interventions by the tool will generate respective

disease at the level of implementation. If

disease and by PC intervention. Before disease for which you need the report. Follow

the Joint Report (see the instruction for

The Critical Zone:
Where supply chain
math lives.

SUMMARY worksheet



The current version should be used in countries **endemic** for **Loiasis**

PC Joint Reporting Form v.4.2 (Loa)

Country	Motanga	Year	2023
---------	---------	------	------

National authorities are requested to complete the **Joint Reporting Form (JRF)** for submission to the World Health Organization **within 3 months** after the last round was implemented and **no later than 31 March** of the next implementation year.

[Click here](#)

[Generate Report](#)

[Click here](#)

Number of people received treatment (at least once) for the diseases (all areas) and geographical coverage (%)

	PreSAC	SAC	Adults	Total	Geographical
Lymphatic filariasis		817,078	1,487,770	2,304,848	100.00
Onchocerciasis	Not eligible	979,077	1,764,835	2,743,912	100.00
Soil-transmitted helminthiases		913,331	1,487,770	2,401,101	100.00
Schistosomiasis		887,443		887,443	75.00

Number of people in need (in areas requiring PC) received treatment for the diseases and national coverage (%)

	PreSAC	SAC	Adults	Total	National
Lymphatic filariasis				1,366,562	37.34
Onchocerciasis	Not eligible	979,077	1,764,835	2,743,912	65.59
Soil-transmitted helminthiases		456,139	418,769	874,908	60.74
Schistosomiasis		813,842		813,842	15.88

Number of people treated by PC intervention and programme coverage (%)

	PreSAC	SAC	Adults	Total	Programme
MDA 1 (IVM+ALB)	Not eligible	817,078	1,487,770	2,304,848	83.19
MDA 3 (IVM)	Not eligible	161,999	277,065	439,064	53.24
MDA 4 (ALB/2*ALB)					
T 1 (PZQ+ALB/MBD)	Not targeted	488,772	Not targeted	488,772	24.45
T 2 (PZQ)		398,671		398,671	30.65
T 3 (ALB/MBD) - round 1		22,402		22,402	8.55
T 3 (ALB/MBD) - round 2					
T 3 (ALB/MBD) - round 3					

Inventory of PC medicines in the country

	IVM	DEC	ALB (LF)	ALB (STH)	MBD	PZQ
Available						
Distributed						
Wasted						
Received						
Remaining						

Please indicate the medicine has been used to treat PreSAC for STH and delivery channels

PC medicine		Delivery channels		Source	
-------------	--	-------------------	--	--------	--

Additional information

JRF Inventory Logic: The Golden Equation



Opening Stock + Received

Opening stock at the beginning of the reporting period.
(Do NOT include newly received stock here)



Opening Stock Only

Opening stock at the beginning of the reporting period.
(Do NOT include newly received stock here)



Medicines newly arrived during the reporting period.



Medicines actually used during implementation
(Exclude warehouse transfers).



Expired, damaged, lost, or destroyed inventory.



The final count after implementation.

Today

December 31st

Diagnostic Matrix: Clarifying Past vs. Future Tools

Dimension	JRF Inventory Table	JRSM Summary Table
Temporal Direction	Backward-looking (Past)	Forward-looking (Future)
Primary Output	Remaining Stock Balance	Requested Additional Quantity
The "Dec 31st" Meaning	Actual physical count as of Dec 31st	Estimated mathematical forecast before new campaigns
Common Pitfall	Adding new receipts to Opening Stock	Using "Today's Stock" instead of the Dec 31st estimate

Navigating the JRSM: The Forward Request

The JRSM tool assists in quantifying tablets needed to reach planned targets.

Before generating the report, verify specific disease selections.

JRSM Structure Overview

Structure of the application (worksheets):

INTRO	This worksheet includes guides on how to complete the joint request for selected PC medicines and information about the status of PC for endemic diseases in the country.
COUNTRY_INFO	This worksheet includes information about administrative structure of the country, population by age group, status of endemicity for each disease, population requiring PC and planned interventions.
DEC, ALB_MBD, PZQ and IVM	These worksheets include information about endemic districts targeted for treatment with specified PC medicines, treatment plan, and number of tablets required and requested.
SUMMARY	This worksheet includes summary of number of tablets requested, information about stock, and date for submission of requested medicines. Before generating the report (run macros) please select the medicines for which the report is needed. Follow the same rule to see the number of people to be treated.

JRSM Summary: Detailed Request Table

Country	Motanga			Year	2025	
Information on PC medicines requested to						
PC medicine	Target group	Number of tablets				Specify source
		Required	In stock	In pipeline	Requested	
Diethylcarbamazine citrate	ALL					
Ivermectin	ALL	10,067,036			10,067,036	
Albendazole for LF	ALL	1,716,152			1,716,152	
Albendazole for STH	PreSAC					
	SAC	260,231			260,231	
	WRA	260,857			260,857	
	WRA	250,173			255,172	
Mebendazole	PreSAC	255,173			255,173	
	SAC					
	WRA					
	WRA					
Praziquantel	PreSAC					
	SAC	2,697,398			2,697,398	
	Adults	10,025,217			10,025,217	

The Forecasting Core. Output is a quantifiable request for donated PC medicines.

SUMMARY worksheet

Country	Motanga	Year	2025
---------	---------	------	------

Information on PC medicines requested to WHO

PC medicine	Target group	Number of tablets				Specify source
		Required	In stock	In pipeline	Requested	
Diethylcarbamazine citrate	ALL					
Ivermectin	ALL	10,067,036			10,067,036	
Albendazole for LF	ALL	1,716,152			1,716,152	
Albendazole for STH	PreSAC					
	SAC	260,231			260,231	
	WRA	260,857			260,857	
Mebendazole	PreSAC	255,173			255,173	
	SAC					
	WRA					
Praziquantel	PreSAC					
	SAC	2,697,398			2,697,398	
	Adults	10,025,217			10,025,217	

Number of people to be treated with donated medicine (see User Guide for details)

Disease		Round 1	Round 2	Round 3
Lymphatic filariasis	These figures are estimated only for targeted age groups to be treated with donated medicines in areas where treatment for a specific disease is planned	1,716,152		
Onchocerciasis		3,595,370		
Schistosomiasis		4,690,438		
Soil-transmitted helminthiasis		1 440 526		

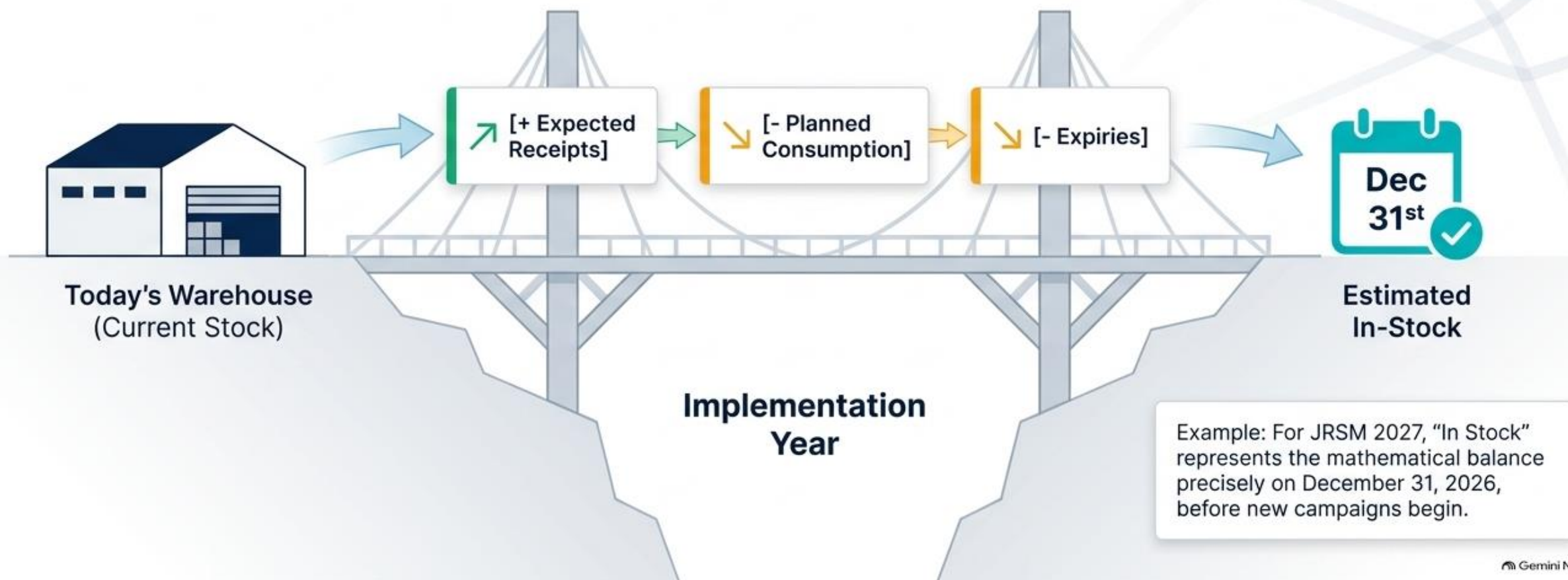
[Click here](#)

Generate Request

[Click here](#)

Demystifying the 'In-Stock' Rule for Forecasting

"In Stock" is the estimated stock expected to remain on Dec 31st of the application year, **NOT** the physical stock sitting in the warehouse today.

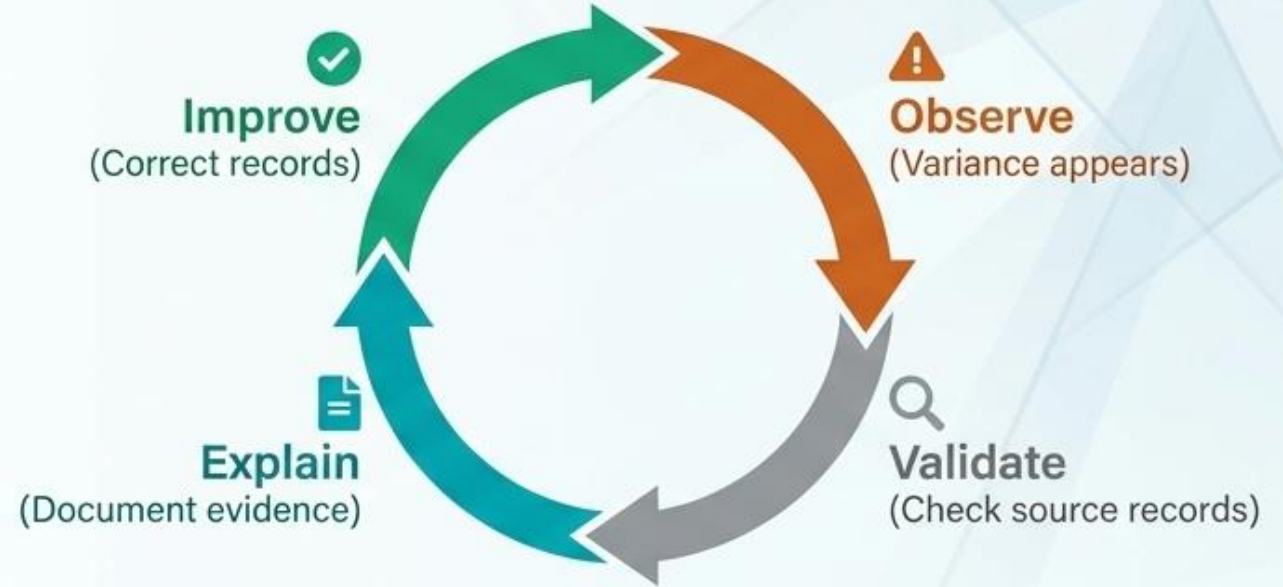


Resolving gaps requires a framework of shared accountability



Accountability is shared. Approval must be documented jointly. No single function can reconcile the system alone.

Continuous Improvement: Building accuracy from the bottom up



The Diplomatic Principle

Focus first on the data and process; agree accountability from verified evidence.

Final Takeaway

Accuracy at the national level cannot exceed the quality of the local records at the treatment point. Good reporting is built from the lowest level upward.

•THANK
•YOU



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING NTD Data Use, Reporting and Supply Chain Capacity

Kintélé, Brazzaville,
Republic of the Congo

ESPEN DIGITAL ECOSYSTEM OVERVIEW: ESPEN NTD PORTAL

Dr Jorge Cano, Surveillance officer



Overview

- Why data matters for PC-NTDs
- From Data to Action
- What programmatic decisions rely on data?
- Case Studies
- NTD Data Repositories: Landscape
- The ESPEN NTD Portal – *Evolution*
- ESPEN NTD Platforms - Ecosystem

Why Data Matters for NTD Programmes

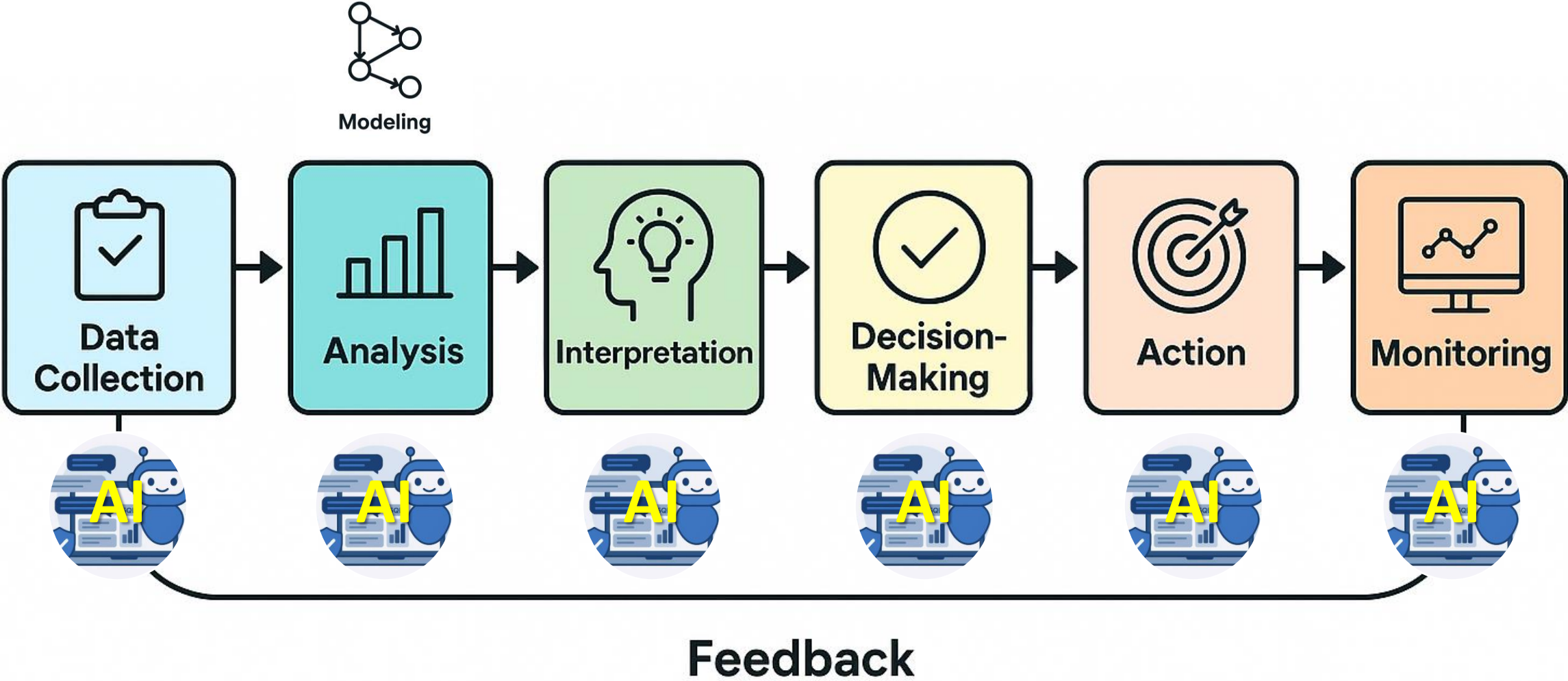
Challenges (*some*) in NTD Programme Implementation

- **Limited resources:** Funding gaps and shifting donor priorities
- **Large and dispersed target populations**
- **Evolving epidemiological landscapes:** transmission patterns shift
- **Fragmented data systems:** Vertical programs often use parallel systems
- **Need for targeted interventions:** as reaching the endgame risk for persistent hotspots of transmission

The Role of Data in Addressing these challenges

- **Precision:** Identify exact areas and populations that still require treatment or intensified surveillance.
- **Equity:** Ensure interventions reach the most vulnerable, marginalized, or high-burden areas.
- **Efficiency:** Use available funding, medicines, and personnel where they will have the greatest impact.
- **Accountability:** Track progress, justify investment, and communicate success to partners and communities.

From Data to Action



What Decisions Rely on Data?

-  **Planning MDA Campaigns:**
 - Identify where, when, and for whom mass drug administration should occur based on population at risk and treatment history.
-  **Prioritizing Interventions Geographically:**
 - Focus limited resources on high-burden or persistent-transmission areas using IU-level endemicity maps and coverage data.
-  **Adjusting to Epidemiological Trends:**
 - Respond to new survey results, shifting disease prevalence, or coverage gaps by refining treatment strategies or intensifying monitoring.
-  **Morbidity Management and Disability Prevention (MMDP):**
 - Use data to identify where morbidity services (e.g., for LF or trachoma) are needed and ensure service integration with routine systems.
-  **Evaluating Impact and Stopping Treatment:**
 - Determine if disease transmission thresholds have been met to stop MDA (based on TAS, pre-stop surveys, and longitudinal trends).
-  **Securing and Allocating Funding:**
 - Use performance data to advocate for continued support and guide equitable distribution of funds, medicines, and technical resources.

Case Study 1 – Planning Based on Coverage Gaps

NTD Index

		Population (in 1000) requiring treatment by disease, 2020				
		LF	ONCHO	SCH	STH	TRA
Angola	Y	3,819	5,948	3,258	3,371	No data
Benin	Y	315	5,599	1,367	2,105	0
Botswana	Y			367	194	No data
Burkina Faso	Y	2,187	285	4,285	Surveillance	0
Burundi	Y		2,008	1,634	2,296	0
Cabo Verde	Y			150		
Cameroon	Y	58	11,348	3,330	3,834	323
Central African Republic	Y	4,443	2,606	478	997	3,531
Chad	Y	5,352	6,153	2,378	545	270
Comoros	Y	400			255	
Congo	Y	1,062	767	225	833	
Côte d'Ivoire	Y	21,966	19,169	3,835	2,396	7,863
Democratic Republic of the Congo	Y	47,298	50,806	11,522	31,592	13,265
Equatorial Guinea	Y	420	99	32	145	
Eritrea	Y	72		244		126
Eswatini	Y			282	17	
Ethiopia	Y	6,831	24,391	7,775	29,073	75,731
Gabon	Y	358	722	160	430	
Gambia	Y			98	71	0
Ghana	Y	1,350	7,622	4,369	10,904	Eliminated
Guinea	Y	8,181	7,746	1,865	2,336	235
Guinea-Bissau	Y	1,892	566	108	377	27
Kenya	Y	4,103		1,924	5,938	3,860
Lesotho	Y				387	
Liberia	Y	2,949	3,160	448	899	
Madagascar	Y	21,390		4,439	7,381	
Malawi	Y		2,491	3,735	7,635	0
Mali	Y	Surveillance	6,326	3,518	Surveillance	0
Mauritania	Y			391		0
Mozambique	Y	19,099		6,264	11,892	4,718
Namibia	Y			204	811	No data
Niger	Y	4,135		4,553	Surveillance	4,868
Nigeria	Y	136,378	51,731	17,444	46,247	7,984
Rwanda	Y			1,685	3,912	
Sao Tome and Principe	Y	210		81		
Senegal	Y	5,591	338	1,341	1,271	0
Sierra Leone	Y	1,655	7,151	1,309	3,256	
South Africa	Y			3,808	15,682	
South Sudan	Y	8,561	8,571	1,324	678	3,301
Togo	Y	Eliminated	3,820	1,740	2,523	0
Uganda	Y	Surveillance	1,581	5,628	16,494	700
United Republic of Tanzania	Y	8,238	6,576	6,751	19,294	1,481
Zambia	Y	12,810		2,338	4,447	2,348
Zimbabwe	Y	8,030		2,022	589	3,666
Djibouti	Y				111	
Egypt	Y	Eliminated		1,464		1,945
Somalia	Y			2,550	2,697	No data
Sudan	Y	10,867	161	4,517	1,218	3,499

Data source: PC Data Portal, Department of Control of Neglected Tropical Diseases, accessed 29 December 2021



Coverage by disease, 2020						NTD Index	
LF	ONCHO	SCH	STH	TRA		2019	2020
25	34	14	12	ND		15	19
83	82	69	59	100		20	77
		0	63	ND		0	3
78	70	100	100	100		89	89
	82	100	98	100		93	95
			55			63	55
0	36	99	36	0		16	4
0	0	0	0	16		60	0
78	68	15	26	0		65	12
50			22			68	33
33	30	33	41			12	34
48	74	100	82	25		65	59
9	0	0	4	14		74	1
0	0	0	0			0	0
51		8		72		57	31
		0	0			3	0
29	73	0	33	24		65	11
0	0	0	41			0	0
		0	0	100		8	1
0	0	0	0	100		73	0
64	65	61	87	91		0	73
22	70	0	19	87		11	12
O(NR)		O(NR)	O(NR)	25		39	0
						48	0
0	0	0	0			87	0
13		60	49			37	34
100	84	79	39	100		90	76
100	79	97	100	100		24	95
		72		100		75	85
77		81	45	0		68	13
		0	0	ND		0	0
78		59	100	30		0	0
55	75	55	44	53		76	56
		78	94				
72		0	60			66	8
70	88	69	3	100		62	42
70	75	52	44			73	59
		0	0			2	0
0	0	11	31	11		18	2
100	84	100	57	100		77	86
100	85	47	62	57		18	68
0	28	47	38	0		41	3
51		65	23	0		2	9
0		16	0	44		0	2
			0			0	0
100		99		0		53	10
		100	81	ND		2	90
O(VAL)	O(VAL)	0	O(NR)	21		43	0

Not on track
Progress
On track
Not requiring P
0
O(NR)
O(VAL)

76 (2019) / 56 (2020)

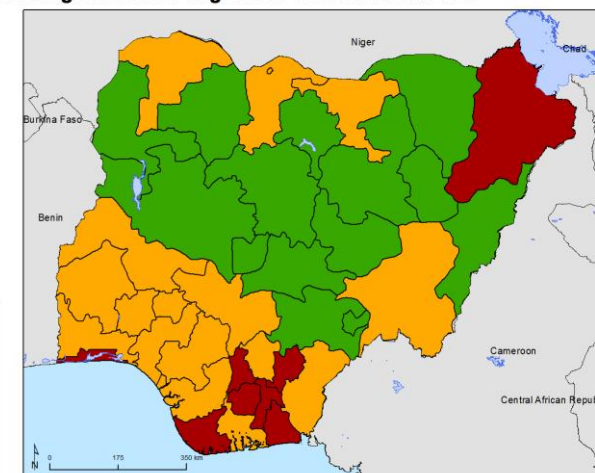
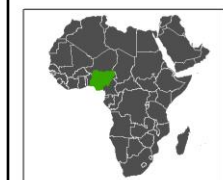
NTD Coverage Index for Nigeria at state level in 2020

Nigeria

NTD Coverage Index

On track
Progress but more effort required
Not on track
NA

Calculation of an NTD coverage index:
This note proposes an NTD coverage index based on the geometric mean of coverage rates for those interventions for which data is routinely reported by countries to WHO.



Disclaimer: The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.
Data source: Data provided by health ministries to ESPEN through WHO reporting process. All reasonable precautions have been taken to verify this information.
Map production: ESPEN/AFRO/WHO NTD Mapping project funded by the Bill & Melinda Gates Foundation.
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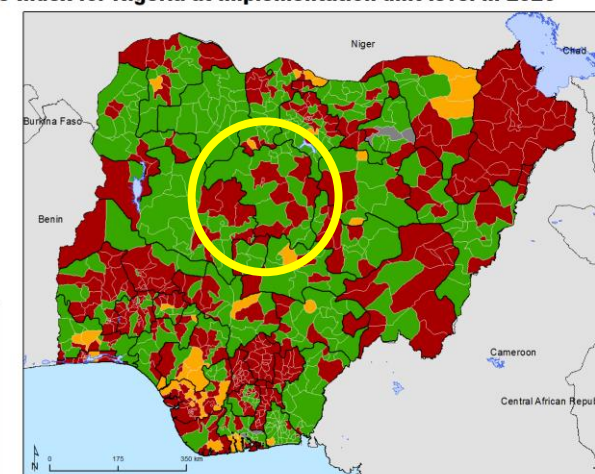
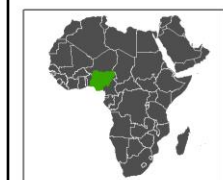
NTD Coverage Index for Nigeria at implementation unit level in 2020

Nigeria

NTD Coverage Index

On track
Progress but more effort required
Not on track
NA

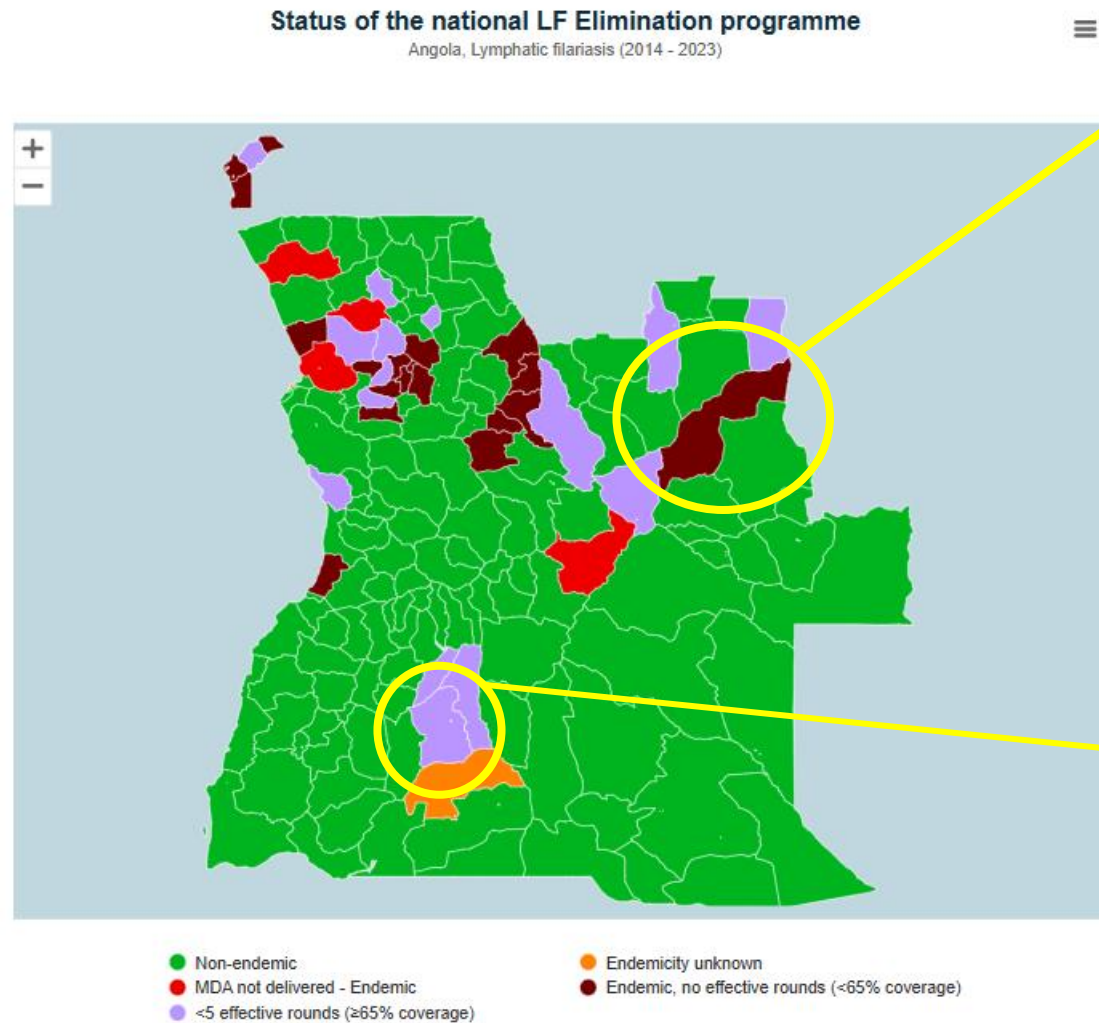
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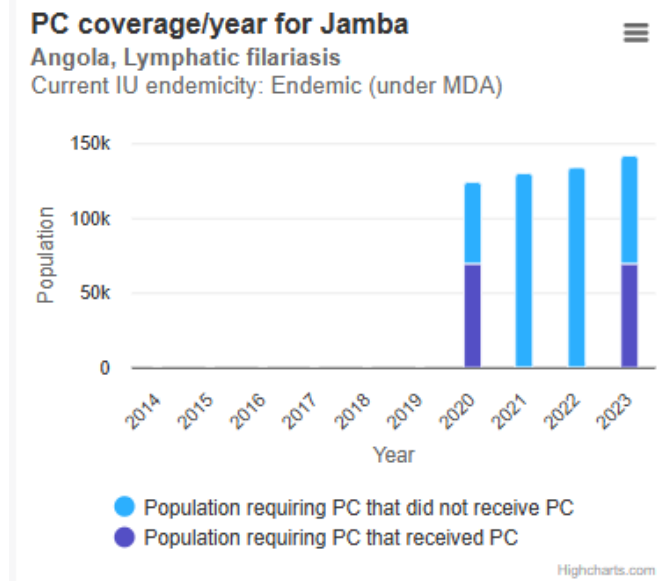
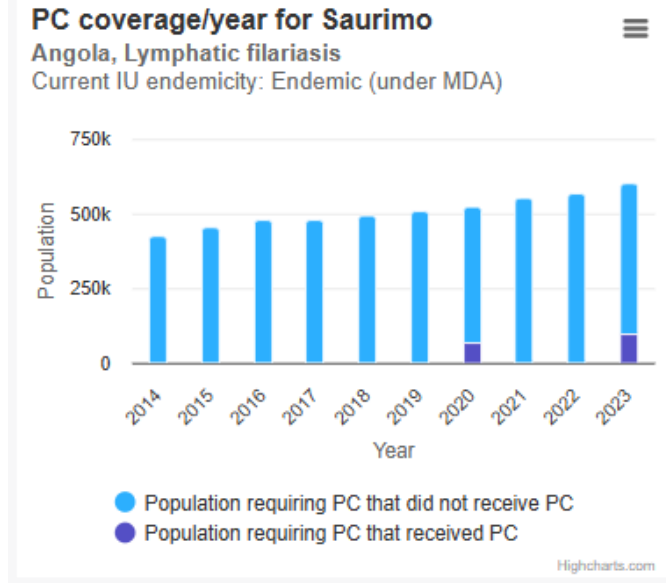


Case Study 1 – Planning Based on Coverage Gaps



Saurimo: *Endemic, no effective rounds (<65%)*

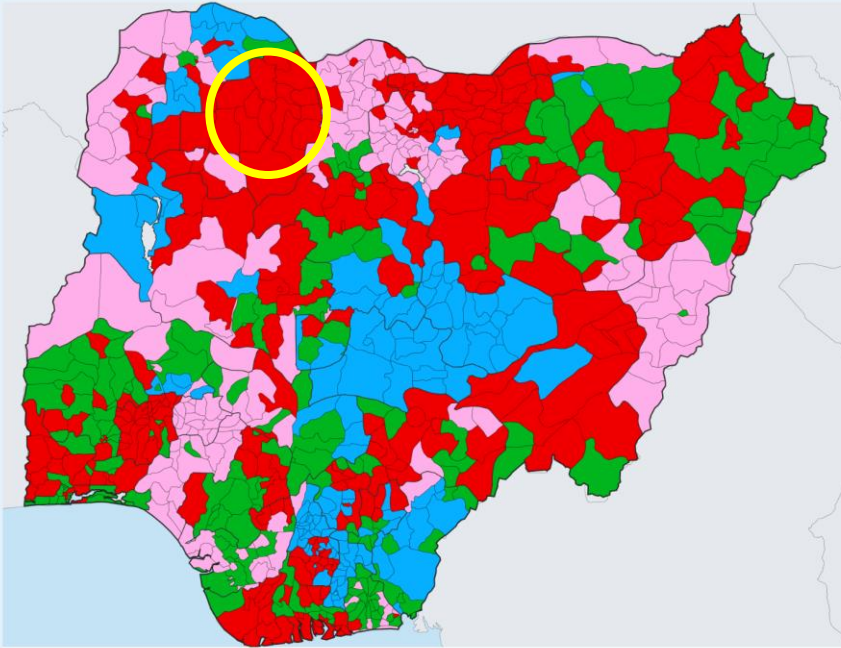
Jamba: *< 5 effective rounds (≥65%)*



Case Study 2 – Stopping MDA Based on Impact Survey Data

Nigeria (2023)

Status of Lymphatic filariasis Elimination



694km

Lymphatic filariasis > Endemicity

- Non-endemic
- Endemic (requiring MDA)
- Endemic (pending IA)
- Under post-intervention surveillance
- Endemicity unknown
- No data available

Boundaries, names and designations used here do not imply expression of WHO opinion concerning the legal status of any country, territory or area, or of its authorities, or concerning delimitation of frontiers or boundaries. Dotted / dashed lines represent approximate border lines for which there may not yet be full agreement.

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Zamfara State

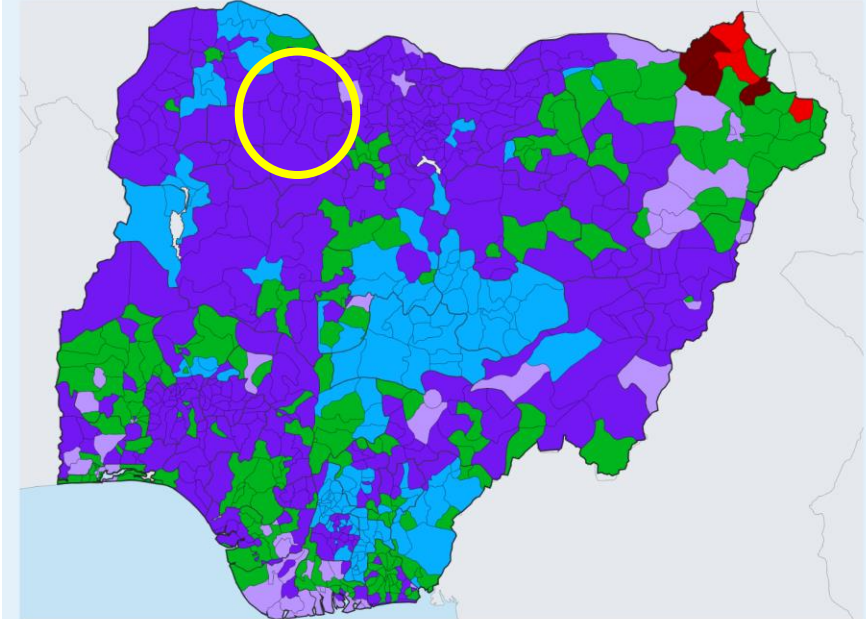
LGAs with a history of more than 5 effective rounds since 2013, yet to implement pre-TAS/EMS

- Failed pre-TAS in the past?
- Inertia?
- Available support?

Exceeding required rounds may lead to inefficient use of resources

Nigeria (2013 - 2023)

Number of MDA rounds for Lymphatic filariasis (Therapeutic coverage)



724km

Lymphatic filariasis > MDA/PC rounds > Therapeutic coverage

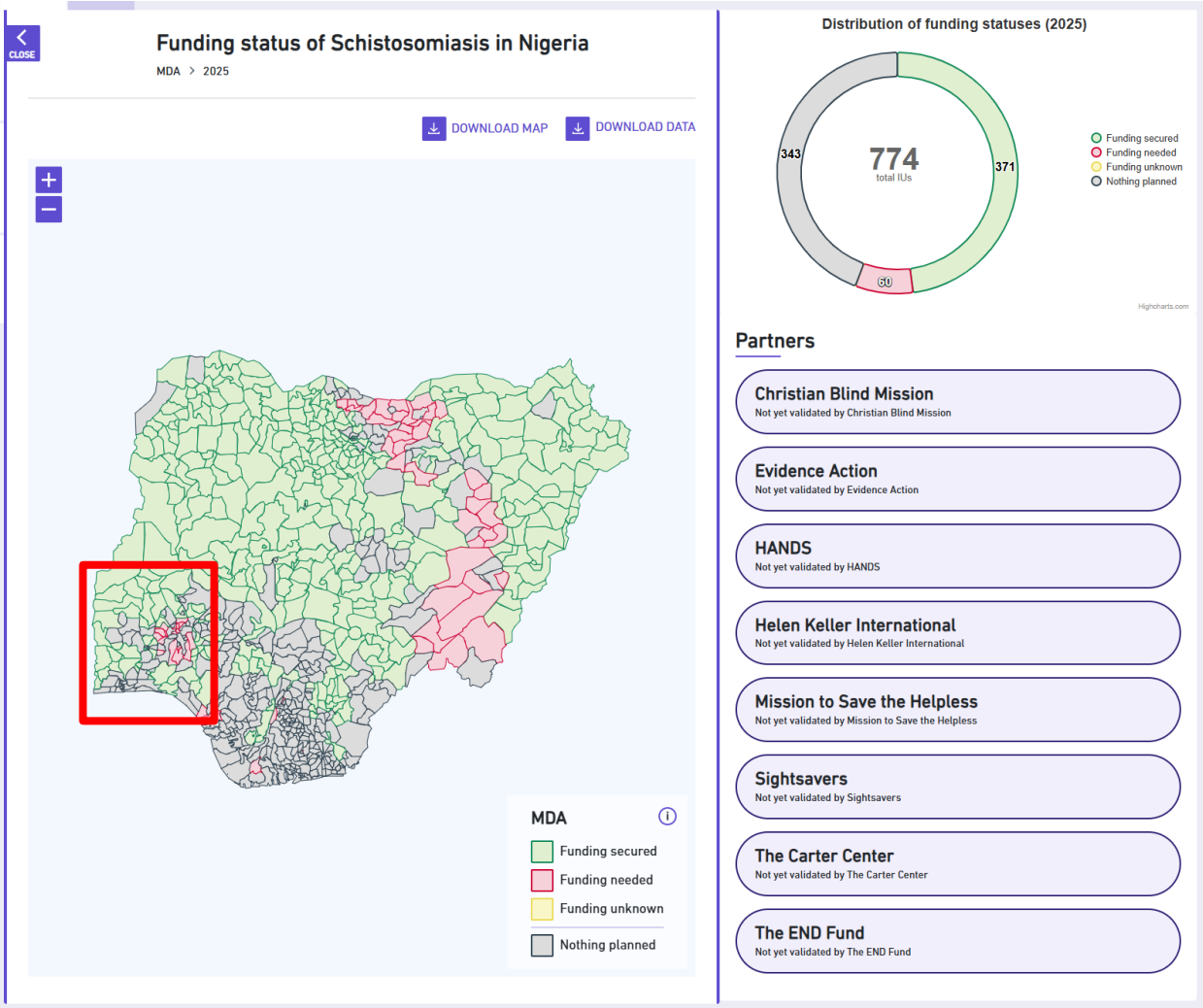
- Non-endemic
- Endemicity unknown
- MDA not delivered - Endemic
- Endemic, no effective rounds (<65% coverage)
- <5 effective rounds (~65% coverage)
- >=5 effective rounds (>=65% coverage)
- Under post-intervention surveillance
- No data available

Boundaries, names and designations used here do not imply expression of WHO opinion concerning the legal status of any country, territory or area, or of its authorities, or concerning delimitation of frontiers or boundaries. Dotted / dashed lines represent approximate border lines for which there may not yet be full agreement.

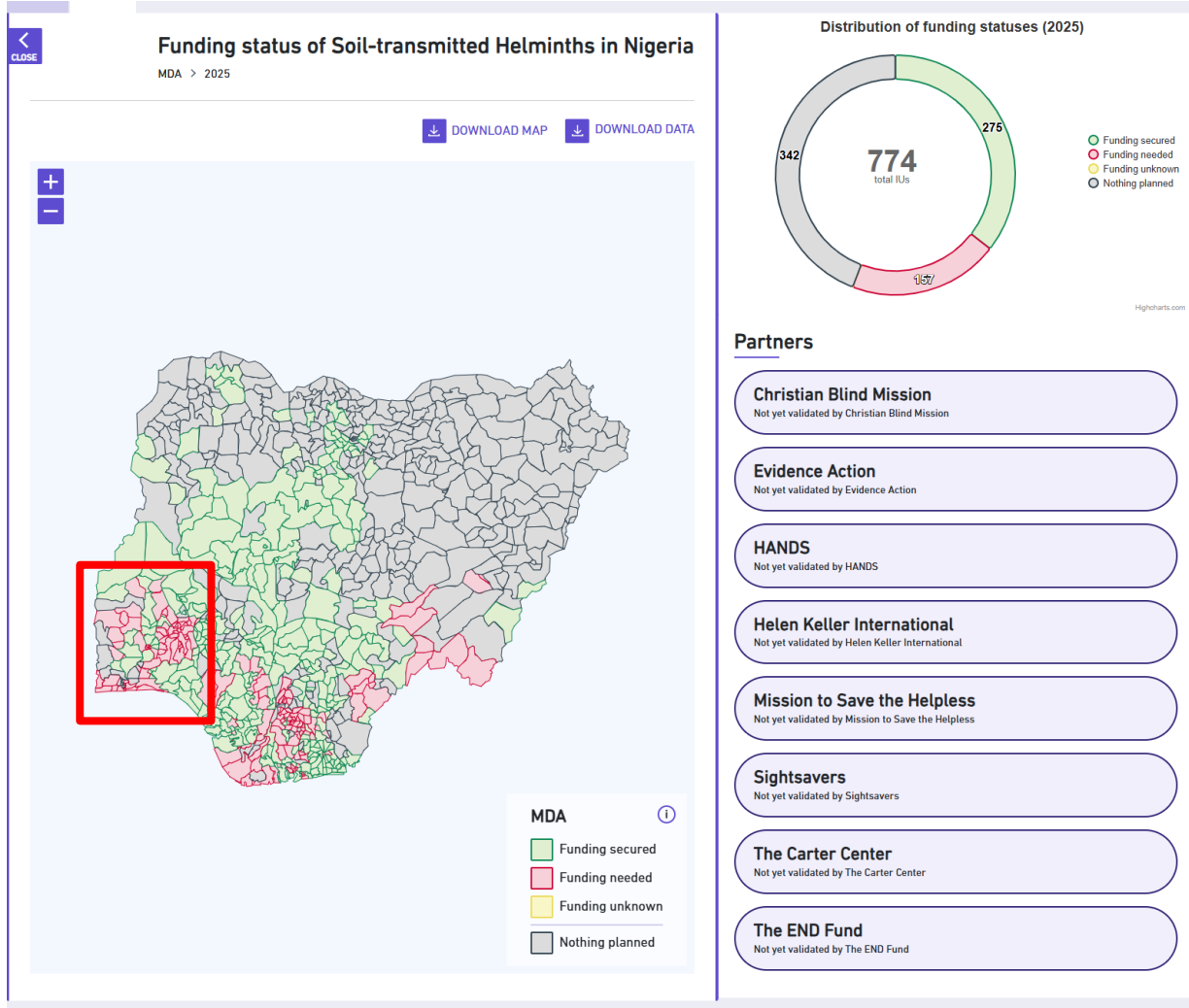
Data Source: Data provided by health ministries to ESPEN through WHO reporting processes. All reasonable precautions have been taken to verify this information.
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Case Study 3 – Integrating Data to Improve Efficiency



Funding gap: 60 LGAs



Funding gap: 157 LGAs

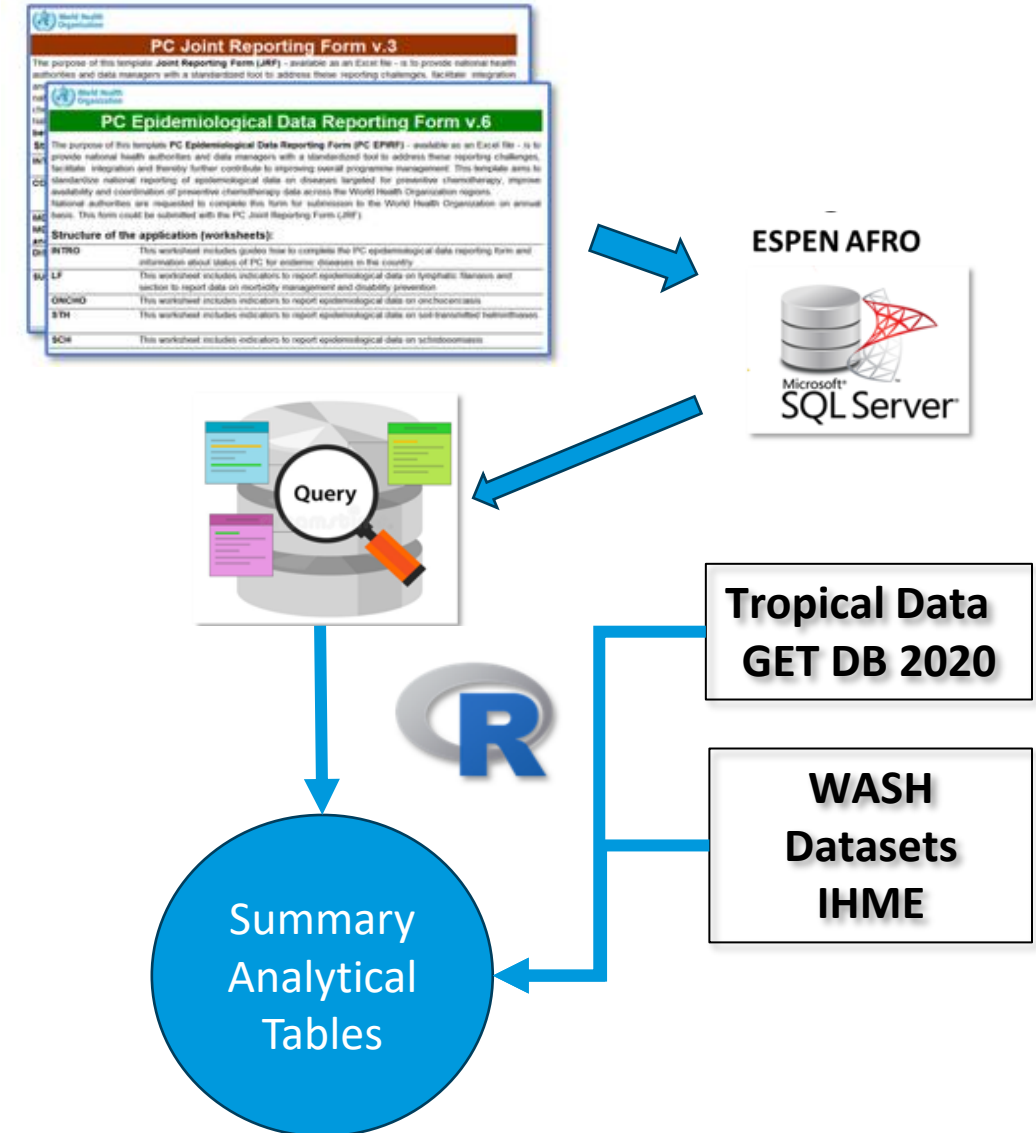
<https://espen.iuplanner.app/>

NTD Data Repositories & Analytics

NTD Data Repository	Host	URL	NTDs	Keep updated?	Geographical level	Data Analytics	Open Data
Global Atlas of Helminth Infections	LSHTM (LASER)	https://www.thiswormyworld.org/	LF, STH, SCH	No	Surveys (locations)	No	Yes
Global Neglected Tropical Diseases Database (GNTD)	Swiss TPH	https://www.gntd.org/	STH, SCH	Unknown	Surveys (locations)	No	Upon request
NTD Road Map Tracker	WHO	https://www.who.int/teams/control-of-neglected-tropical-diseases/data-platforms-and-tools	NTD Road Map indicators	Yes	Global, WHO regions	Yes	No
NTD Country Profile	WHO		All NTDs	Yes	Country	Yes	No
PC Data Portal	WHO		PC-NTDs	Yes	Global, WHO regions, Country	Yes	Yes
ESPEN NTD Portal	WHO (AFRO)	https://espen.afro.who.int/	PC-NTDs	Yes	Site, IU, Country, African regions, EMRO	Yes	Yes
Trachoma Atlas	ITI	https://www.trachomaatlas.org/	Trachoma	Yes	IU	No	No

ESPEN Data Portal - <https://espen.afro.who.int/>

- NTD Data Portal launched by ESPEN in April 2017.
- Aims to be top public NTD data hub.
- Compiles PC-NTD data from countries using JAP & TEMF reports.
- Helps guide NTD control and elimination strategies.
- Not just data storage:
 - ESPEN Collect for data collection.
 - JAP Upload tool for data reporting.
 - Tools for data visualization: graphs, dashboards, maps.
 - Includes NTD Master Plans, Updated Cartography, Elimination estimates.
- Offers APIs for external app development.



ESPEN Data Portal – v3.0 (2024)

Accelerating elimination of NTDs - Towards 2030

The ESPEN Portal enables health ministries and stakeholders to share, and exchange subnational programme data, in support of the NTD control and elimination goals.

1.4 billion people affected by NTDs worldwide	39% of the global burden occurs in Africa	518.6 million people require treatment for PC-NTDs in Africa
8 countries have eliminated at least 1 PC-NTD in the African region	61.3% reduction population requiring MDA for lymphatic filariasis in Africa	289 million received treatment for at least 1 PC-NTD in 2023 in the African region

ESPEN Portal v4.0

- **Launched in May 2025**
- Automated generation of static maps
- Contents and products in multiple languages
- Upgraded architecture:
 - ✓ Faster
 - ✓ More user-friendly
 - ✓ New Features, including a **Generative AI agent (NTD AI Assistant)**
 - ✓ More emphasize in contents and news

ESPEN Data Portal – v4.0 (2025)

What are you looking for?

**Map search**
Looking for a specific map?

**Data search**
Looking for just the data?

**JAP search**
Looking for JAP files?

Latest updates



19 May 2025
Mauritania eliminates trachoma as a public health problem

Update



05 May 2025
Strengthening integrated health campaigns: The Collaborative Action Strategy (CAS) for Health Campaign Effectiveness

Update



30 April 2025
Evaluation report from the 2025 NTD Programme Managers' meeting : Now available

Update



24 April 2025
New ESPEN report reveals how African NTD Programmes are adapting amid funding shortfalls

Update

Site highlights



Maps & data for 48 countries

Browse over 15,000 maps, country data, charts and more



Tools & resources

A wide selection of tools & resources to support the NTD community



Dashboards

LF, Oncho, SCH & STH progress and forecast dashboards for each country



Updates & events

Keep up-to-date on the latest NTD news and events



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

Logins English



World Health Organization
REGIONAL OFFICE FOR
Africa

Maps & data Updates & Events Opportunities Tools & resources About

Accelerating elimination of NTDs - Towards 2030

The ESPEN Portal enables health ministries and stakeholders to share, and exchange subnational programme data, in support of the NTD control and elimination goals.



1.5 billion

people affected by NTDs worldwide

39%

of the global burden occurs in Africa

518.6 million

people require treatment for PC-NTDs in Africa

8 countries

have eliminated at least 1 PC-NTD in the African region

61.3% reduction

population requiring MDA for lymphatic filariasis in Africa

289 million

received treatment for at least 1 PC-NTD in 2023 in the African region

ESPEN NTD Portal
<https://espen.afro.who.int/>

ESPEN NTD Portal: A Central Hub for Data-Driven Technical Support



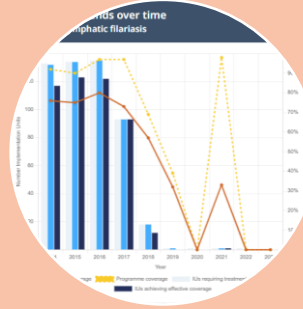
Data Collection

- **ESPEN Collect Platform** – Real-time field data capture
- **ESPEN Spatial Microplanning Tool** – Supports IU-level planning
- **ESPEN Schisto Mapper** – Visualizes SCH risk and informs mapping decisions



Data Reporting

- **JAP Upload Tool** – Facilitates structured online submission of treatment data, surveys, annual working plans and medicine requests



Data Analytics

- **ESPEN Dashboards** – Monitor MDA coverage, endemicity, medicine forecasts, elimination progress



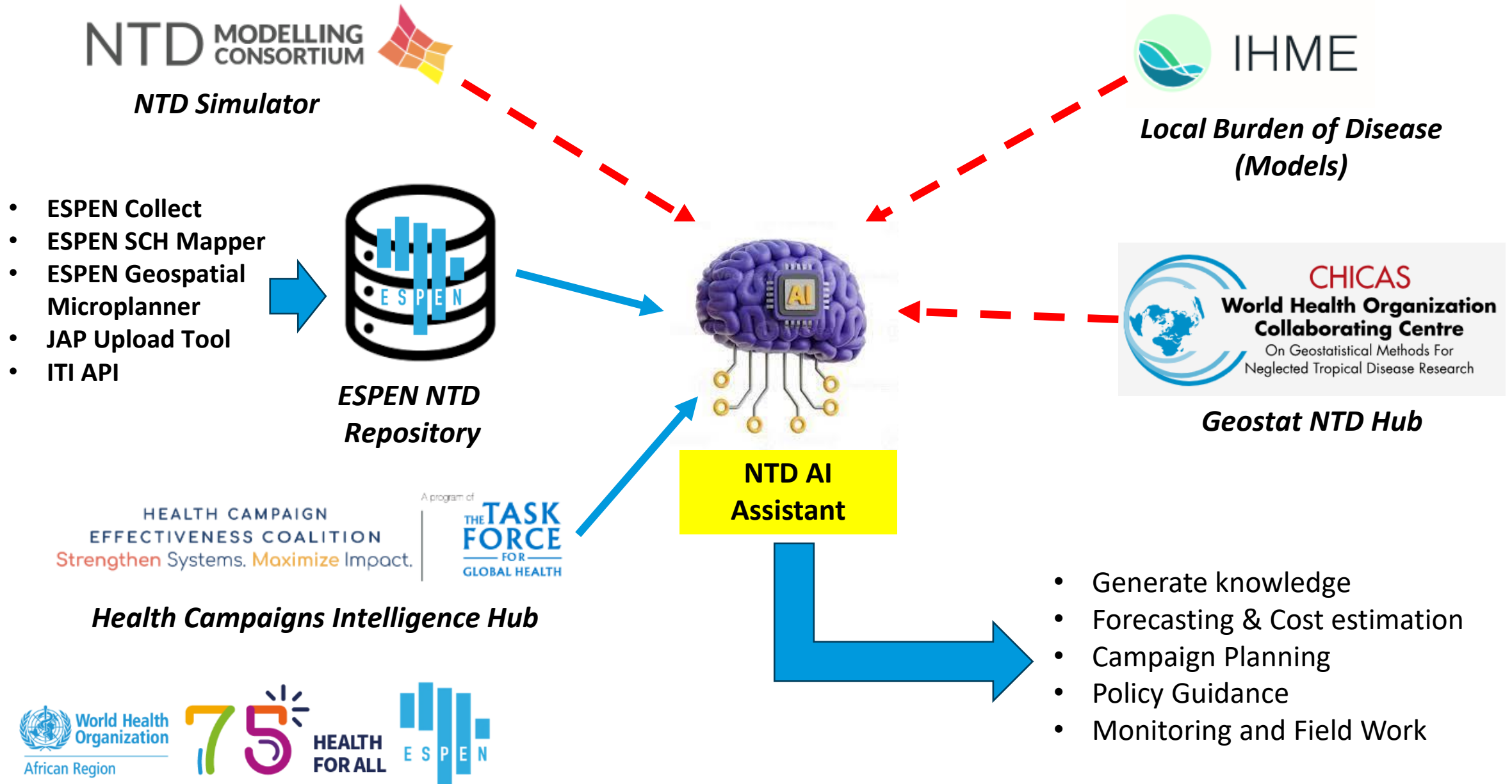
Data Intelligence

- **ESPEN GenAI Assistant** – Conversational AI support for interpreting data, retrieving documents, and generating summaries

ESPEN NTD Portal

<https://espen.afro.who.int/>

ESPEN NTD Platforms Ecosystem (*present & future*)



Thank you to all our partners & donors

...and all country programmes and in-country partners
contributing data to the ESPEN NTD Portal



Current Partners

Gates Foundation

Gates Foundation

CIFF

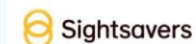
Children's Investment
Fund Foundation



Kuwait Fund for Arab
Economic Development



The End Fund



Sightsavers



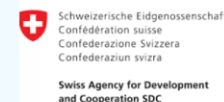
Reaching the last mile



Ministry of Health,
Labour and Welfare for
the Government of Japan



Deutsche Gesellschaft
für Internationale
Zusammenarbeit (GIZ)



Swiss Agency for
Development and
cooperation

Pharmaceutical Donation Partners



GSK

Johnson
& Johnson

Johnson & Johnson

MERCK

Merck Group



Merck Sharp & Dohme-
Chibret



Pfizer



Eisai

•THANK
•YOU



DFPC

Health Promotion,
Disease Prevention and
Control Cluster



ESPE

EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING
NTD Data Use, Reporting and Supply Chain Capacity

Kintélé, Brazzaville,
Republic of the Congo

**Navigating the ESPEN Portal
Dashboards, Maps, and Analytical
Resources**

Dr Jorge Cano, Surveillance officer



DFPC Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

Overview

- Overview of the ESPEN Portal Structure
- Navigating “Maps & Data”: *dashboards, maps & analytics*
- Other Portal sections: *advanced analytics, news & opportunities*
- Wrap-up & Key Messages

Overview of the ESPEN Portal Structure

The screenshot shows the ESPEN Portal homepage. The header includes the ESPEN logo (EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES), a 'JAP Upload Tool' button, a language dropdown set to 'English', and the World Health Organization African Region logo. A navigation bar contains links for 'Maps & data', 'Updates & Events', 'Opportunities & initiatives', 'Tools & resources', and 'About'. The main banner features the title 'Accelerating elimination of NTDs - Towards 2030' and a description: 'The ESPEN Portal enables health ministries and stakeholders to share, and exchange subnational programme data, in support of the NTD control and elimination goals.' A callout box on the right lists the portal's contents: 'Dashboards, Summary indicators & maps', 'Other technical resources', and 'Contents'.

ESPEN EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

JAP Upload Tool

ESPEN Collect

English

World Health Organization African Region

Maps & data ▾ Updates & Events ▾ Opportunities & initiatives ▾ Tools & resources ▾ About ▾

Accelerating elimination of NTDs - Towards 2030

The ESPEN Portal enables health ministries and stakeholders to share, and exchange subnational programme data, in support of the NTD control and elimination goals.

Dashboards, Summary indicators & maps: key treatment and endemicity indicators, dynamic and static maps, and interactive dashboards

Other technical resources: data collection, data reporting, advanced analytics and training resources

Contents: news, updates, newsletters, partnerships and MMM programme.

MAPS & DATA SECTION



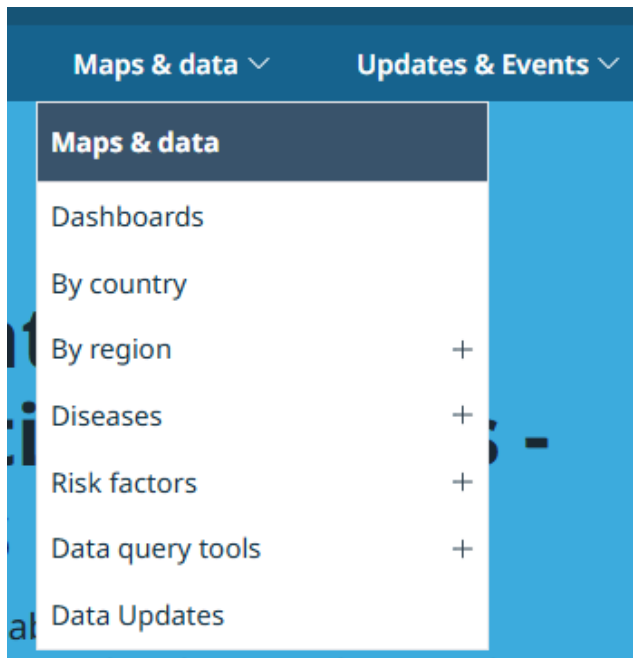
World Health
Organization



HEALTH
FOR ALL



Navigating “Maps & Data”



Dashboards (progress and forecast)

- Interactive visuals that provide **summarized analytics** by disease and country.
- Include **MDA coverage, survey status, population at risk, and intervention timelines**.
- Useful for national- and regional-level monitoring.

By Country / By Region

- Navigate to tailored views that compile all available data by **individual countries** or **multi-country regions (African sub-regions)**.
- Includes **key indicators, maps, dashboards** and **downloads** per NTD.

Data Query Tools*

- Flexible tool that allows users to **custom-filter and download datasets** based on IU, disease, and time period.
- Supports advanced users in preparing reports or conducting deeper analysis.

Dashboards – Progress & Forecast

Dashboards

Please select a **Country** and **Disease**, and either **Progress** or **Forecast** and click **Update** to view the dashboard.

Country Democratic Republic of the Congo Disease Lymphatic filariasis Dashboard Progress Forecast Update

Key statistics for

2023

Population living in IUs requiring PC:

37,428,659 people | 178 IUs

Population living in IUs that have stopped PC:

14,421,858 people | 67 IUs

Population targeted for PC:

30,181,444 people | 178 IUs in total

Population treated with PC:

29,966,556 people | 178 IUs in total
176 IUs achieved effective coverage

Drug regimen

- ALB+IVM in 120 IUs
- ALBx2 in 59 IUs

Coverage indicators

Geographic coverage: **100%** of endemic IUs covered by PC

Programme coverage: **99%** of individuals living in targeted IUs were treated

National coverage: **80%** of individuals requiring PC in the country were treated

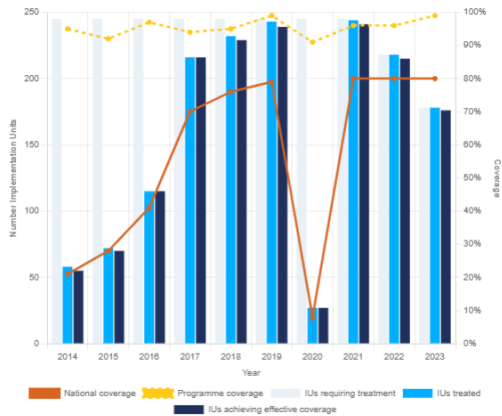
National PC Coverage Democratic Republic of the Congo, Lymphatic filariasis (2023)



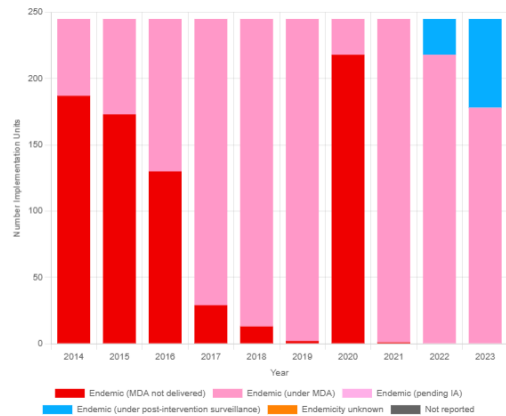
Total population requiring PC 2023 37,428,659

Population requiring PC that received PC Population requiring PC that did not receive PC

PC Coverage trends over time Democratic Republic of the Congo, Lymphatic filariasis

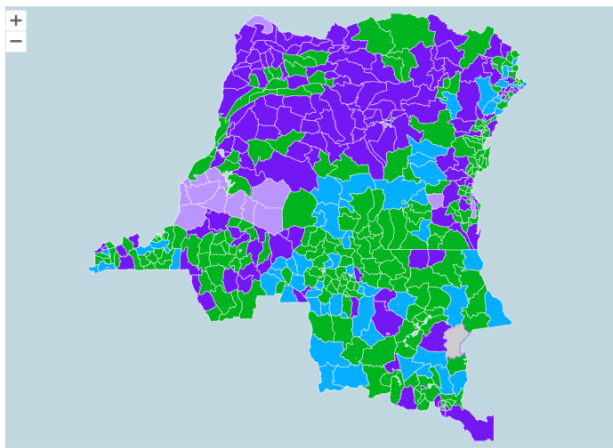


Country progress: % of IUs per Elimination stage Democratic Republic of the Congo, Lymphatic filariasis



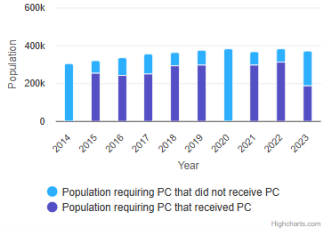
Status of the national LF Elimination programme

Status of the national LF Elimination programme Democratic Republic of the Congo, Lymphatic filariasis (2014 - 2023)



Non-endemic Under post-intervention surveillance <5 effective rounds (≥65% coverage) ≥5 effective rounds (≥65% coverage)

PC coverage/year for Pweto Democratic Republic of the Congo, Lymphatic filariasis Current IU endemicity: Endemic (under MDA)



Region Analytics & Maps

Western Africa



Regional summary statistics for 2023

Demographics					
1,867	421,327,033	61,851,625	116,505,263	227,775,212	14
Number of implementation units (IUs)	Total Population	Total PreSAC Population	Total SAC Population	Total Adult Population	Number of countries reporting data

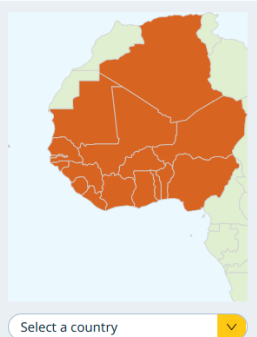
Programme status *			
1,956,841 people	7 IUs	260,937,799 people	1,602 IUs
Population living in IUs with endemicity unknown for at least one PC-NTD		Population requiring PC for at least one PC-NTD	

Delivery of PC in 2023 *			
169,749,810 people	1,278 IUs	146,763,791 people	1,278 IUs
Population targeted with PC for at least one NTD		Population requiring PC for at least one PC-NTD	

*These statistics exclude trachoma, as data are currently reporting using alternative implementation unit information, making integration unfeasible.

Trachoma		
34	12 (35%)	
Number of IU Requiring PC for trachoma	Number of IU Implementing PC for trachoma	

Disclaimer: summary indicators provided here have been obtained from countries that have submitted the Joint Report Form (JRF) for the selected year. These indicators have resulted from aggregating estimates provided at implementation unit level.



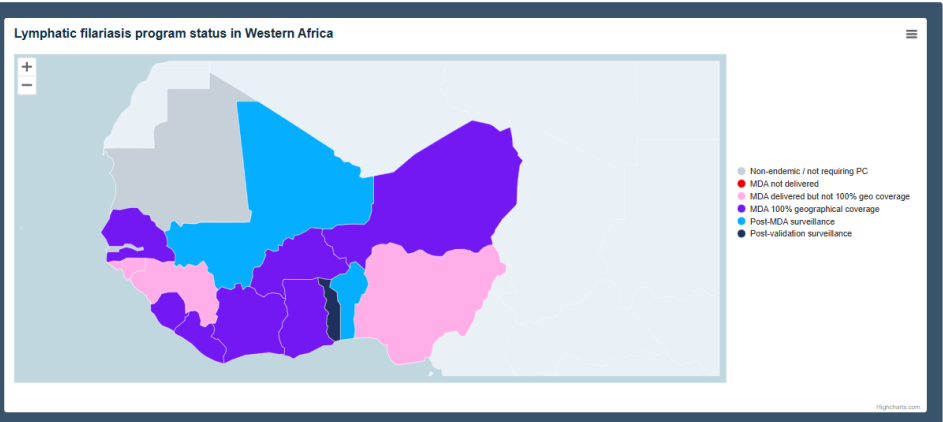
Western Africa comprises 17 countries and is endemic for all five PC-NTDs and loiasis. Most of the region is endemic for LF, or has been historically. Several countries have successfully reduced LF transmission and implement post-MDA surveillance in certain districts. Onchocerciasis occurs throughout the tropical belt covering the southern part of the region. The region is mostly free of Loiasis, although this disease occurs throughout Nigeria. All countries are affected by schistosomiasis and STH, although endemicity levels vary within and between countries.

Western Africa



Introduction

2023



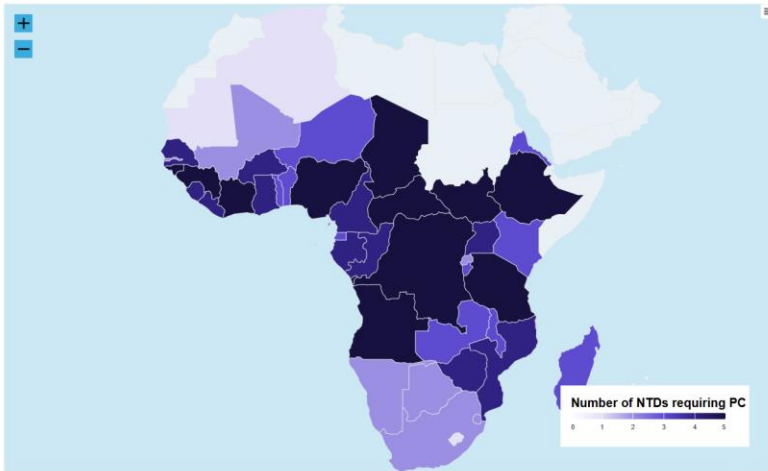
Country Analytics, Maps & Dashboards I

Country maps and data

1

Select a country

Number of NTDs requiring PC in the African region



Central Africa	Eastern Africa	Southern Africa	Western Africa
Angola	Comoros	Botswana	Algeria
Burundi	Eritrea	eswatini	Benin
Cameroon	Ethiopia	Lesotho	Burkina Faso
Central African Republic	Kenya	Malawi	Cape Verde
Chad	Madagascar	Mozambique	Cote d'Ivoire
Democratic Republic of the Congo	Mauritius	Namibia	Ghana
Equatorial Guinea	Rwanda	South Africa	Guinea
Gabon	Seychelles	Zambia	Guinea-Bissau
Republic of the Congo	South Sudan	Zimbabwe	Liberia
Sao Tome and Principe	Tanzania (Mainland)		Mali
	Tanzania (Zanzibar)		Mauritania
	Uganda		Niger
			Nigeria
			Senegal
			Sierra Leone
			The Gambia
			Togo

Nigeria

2

Overview

Introduction

National summary statistics for

Endemic NTDs requiring PC	NTDs targeted with PC
Lymphatic filariasis Onchocerciasis STH Schistosomiasis Trachoma	Lymphatic filariasis Onchocerciasis STH Schistosomiasis Trachoma

Demographics

774	213,000,093	34,080,011	59,640,032	110,760,050
Number of implementation units (IUs)	Total Population	Total PreSAC Population	Total SAC Population	Total Adult Population

Programme status *

0 people 0 IUs	153,772,397 people 730 IUs	52,363,676 people 197 IUs
Population living in IUs with endemicity unknown for at least one PC-NTD	Population requiring PC for at least one PC-NTD	Population living in IUs that have stopped PC for at least one PC-NTD

Delivery of PC in 2023 *

102,849,698 people 660 IUs	90,321,107 people 660 IUs	44 IUs (6% of all endemic IUs)
Population targeted with PC for at least one NTD	Population requiring PC for at least one PC-NTD	IUs achieving effective coverage for all NTDs requiring PC

Reporting

Most recent approved JRF	Most recent approved JRS
2023	2025

*These statistics exclude trachoma, as data are currently reporting using alternative implementation unit information, making integration unfeasible

Looking forwards

151,762,868 treatments to be delivered	647 IUs to be surveyed	447,221,470 treatments to be delivered	1076 IUs to be surveyed	714,267,808 treatments to be delivered	1972 IUs to be surveyed
2020 to 2022		2023 to 2025		2026 to 2030	

For further details of ESPEN forecasts by disease, please refer to the 'Forecast dashboard' under each disease tab.

Nigeria

3

Overview

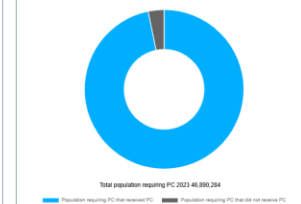
Onchocerciasis

Progress dashboard

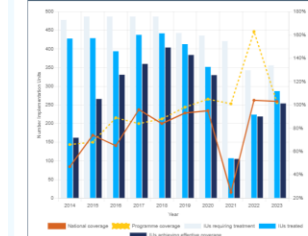
Key statistics for

Population living in IUs requiring PC: 46,890,284 people 356 IUs	Population living in IUs that have stopped PC: 15,758,897 people 128 IUs
Population targeted for PC: 47,536,934 people 287 IUs in total	Population treated with PC: 48,501,753 people 287 IUs in total 254 IUs achieved effective coverage
Drug regimen • ALB+IVM in 155 IUs • IVM in 167 IUs	
Coverage indicators Geographic coverage: 81% of endemic IUs covered by PC Programme coverage: 102% of individuals living in targeted IUs were treated National coverage: 103% of individuals requiring PC in the country were treated	

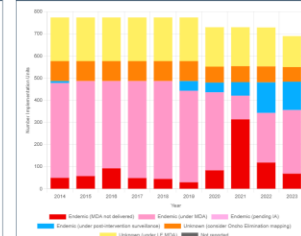
National PC Coverage Nigeria, Onchocerciasis (2023)



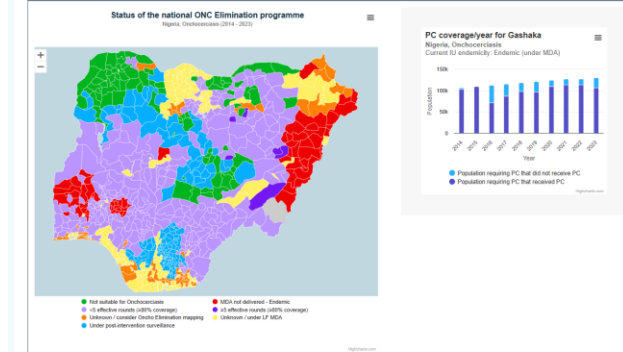
PC Coverage trends over time Nigeria, Onchocerciasis



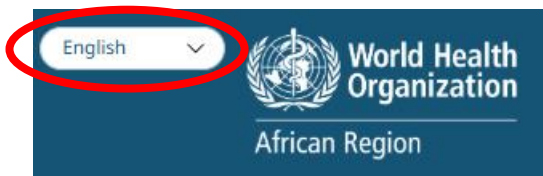
Country progress: % of IUs per Elimination stage Nigeria, Onchocerciasis



Status of the national ONC Elimination programme



Country Analytics, Maps & Dashboards II



English
French
Portuguese

- **On-the-fly map generation**
- Map interface available in **multiple languages**
- **Filter maps by disease, intervention type, and year** across all 5 PC-NTDs
- **Downloadable map layouts** in both portrait and landscape formats
- **Access to underlying datasets** for further analysis



Nigeria

Overview LF **ONC** LOA SCH STH TH WaSH

Onchocerciasis

Progress dashboard Forecast dashboard **Maps** Data

Text search
Type here
Apply Reset

Endemicity × MDA/PC Coverage ×
2023 × 2022 ×

Type +
Sub-type +
Year +

1 - 6 of 6 Items per page 24

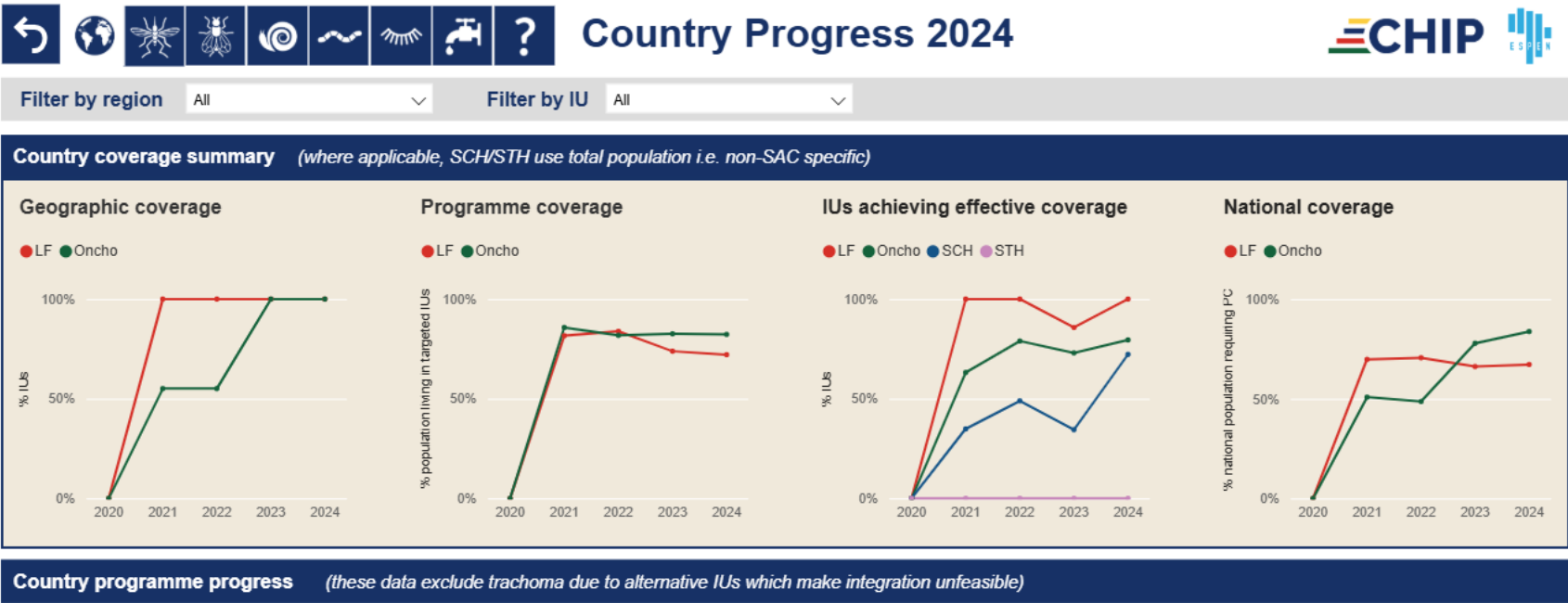
Layout	Map Type	Download Links
Portrait	Nigeria Onchocerciasis 2023	Map PNG Map PDF Data CSV
	Nigeria Onchocerciasis 2022	Map PNG Map PDF Data CSV
	Nigeria Onchocerciasis 2023 MDA/PC Coverage	Map PNG Map PDF Data CSV
Landscape	Nigeria Onchocerciasis 2023	Map PNG Map PDF Data CSV
	Nigeria Onchocerciasis 2022	Map PNG Map PDF Data CSV
	Nigeria Onchocerciasis 2023 MDA/PC Coverage	Map PNG Map PDF Data CSV

Country Health Information Platform (CHIP)



CHIP is a Microsoft Power BI dashboard that aggregates all national data reported on annual reporting forms into a single, interactive dashboard.

National NTD programmes who wish to use CHIP can register using the link below. Once registered, a CHIP dashboard will be setup for their country and they will receive training on the features of the CHIP dashboard. Additionally, CHIP relies on having complete reporting of all programmatic activities on annual reporting forms. Additional support can be provided to national NTD programmes who wish to fill in existing reporting gaps.



OTHER PORTAL SECTIONS



World Health
Organization



HEALTH
FOR ALL



Updates & Events – Stay Informed

W H O

WORLD HEALTH ORGANIZATION

EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

JAP Upload Tool

ESPEN Collect

English

World Health Organization

African Region

Maps & data

Updates & Events

Opportunities

Tools & resources

About

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Updates & Events

Updates

Events

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Accelerating

Updates

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15 July 2025

Senegal joins growing list of countries that have eliminated trachoma

Update

11 July 2025

Burundi eliminates trachoma as a public health problem

Update

25 June 2025 | Brazzaville, Abu Dhabi

Advocacy in Action—Uniting Emerging Leaders to #BeatNTDs

Update

Update

Senegal joins growing list of countries that have eliminated trachoma

15 July 2025



Dakar - Brazzaville - Geneva - The World Health Organization (WHO) has validated Senegal as having eliminated trachoma as a public health problem. Senegal becomes the ninth country in WHO's African Region to have achieved this feat.

"I commend Senegal for freeing its population from this disease," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "This milestone is yet another sign of the remarkable progress being made against neglected tropical diseases globally, and offers hope to other countries still working to eliminate trachoma."

Trachoma has been known in Senegal since the early 1900s and was confirmed as a major cause of blindness through surveys in the 1980s and 1990s. Senegal joined the WHO Alliance for the Global Elimination of Trachoma in 1998, conducted its first national survey in 2000, and completed full disease mapping by 2017 with support from the Global Trachoma Mapping Project and Tropical Data. Trachoma control was consistently integrated into national eye health programming, first under the National Program for Blindness Prevention (PNLB) and later through the National Program for the Promotion of Eye Health (PNPES) – maintaining its commitment to trachoma elimination.

"Today we celebrate our victory against trachoma, 21 years after the one against dracunculiasis," said Dr Ibrahim Sy, Senegal's Minister of Health and Social Action. "This new milestone reminds us that our overarching goal remains a Senegal free from neglected tropical diseases. We are fully committed to this, and we are making good progress, notably against human African trypanosomiasis (sleeping sickness) and onchocerciasis."

Senegal implemented the WHO-recommended SAFE strategy to eliminate trachoma with the support of partners, reaching 2.8 million people who needed them across 24 districts. These activities included provision of surgery to treat the late blinding stage of the disease, conducting antibiotic mass drug administration of azithromycin donated by Pfizer through the International Trachoma Initiative, carrying out public awareness campaigns to promote facial cleanliness, and improvement in access to water supply and sanitation.

Trachoma is the second neglected tropical disease to be eliminated in Senegal. In 2004, the country was certified free of dracunculiasis (Guinea-worm disease) transmission. Globally, Senegal joins 24 other countries that have been validated by WHO for having eliminated trachoma as a public health problem. These are Benin, Burundi, Cambodia, China, Gambia, Islamic Republic of Iran, Lao People's Democratic Republic, Ghana, India, Iraq, Malawi, Mali, Mauritania, Mexico, Morocco, Myanmar, Nepal, Oman, Pakistan, Papua New Guinea, Saudi Arabia, Togo, Vanuatu and Viet Nam. These countries are part of a wider group of 57 countries that have eliminated one or more neglected tropical diseases.

WHO is supporting Senegal's health authorities to closely monitor communities in which trachoma was previously endemic to ensure there is no resurgence of the disease.

"Trachoma has cast a shadow over communities in Senegal for more than a century. This long-awaited validation is not only a milestone for public health but a powerful tribute to the tireless dedication of frontline health workers, communities, government leaders, and partners who never gave up," said Dr Jean-Marie Yamogo, WHO Representative in Senegal. "Today, we close a chapter that began over a hundred years ago, united with pride, gratitude and resolve. WHO remains committed to supporting Senegal as the country continues to lead in sustaining this hard-earned achievement."

Disease prevalence

Trachoma remains a public health problem in 32 countries, with an estimated 103 million people living in areas requiring interventions against the disease. Trachoma is found mainly in the poorest and most rural areas of Africa, Central and South America, Asia, the Western Pacific and the Middle East. WHO's African Region is disproportionately affected by trachoma, with 93 million people living in at-risk areas in April 2024, representing 90% of the global trachoma burden.

Significant progress has been made in the fight against trachoma over the past few years and the number of people requiring antibiotic treatment for trachoma in the African Region fell by 96 million from 189 million in 2014 to 93 million as of April 2024, representing a 51% reduction.

There are currently 20 countries (Algeria, Angola, Burkina Faso, Cameroon, Central Africa Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Guinea, Kenya, Mozambique, Niger, Nigeria, South Sudan, United Republic of Tanzania, Uganda, Zambia and Zimbabwe) in WHO's African Region that are known to require intervention for trachoma elimination. A further 3 countries in the Region (Botswana, Guinea-Bissau and Namibia) claim to have achieved the prevalence targets for elimination.

Editor's note

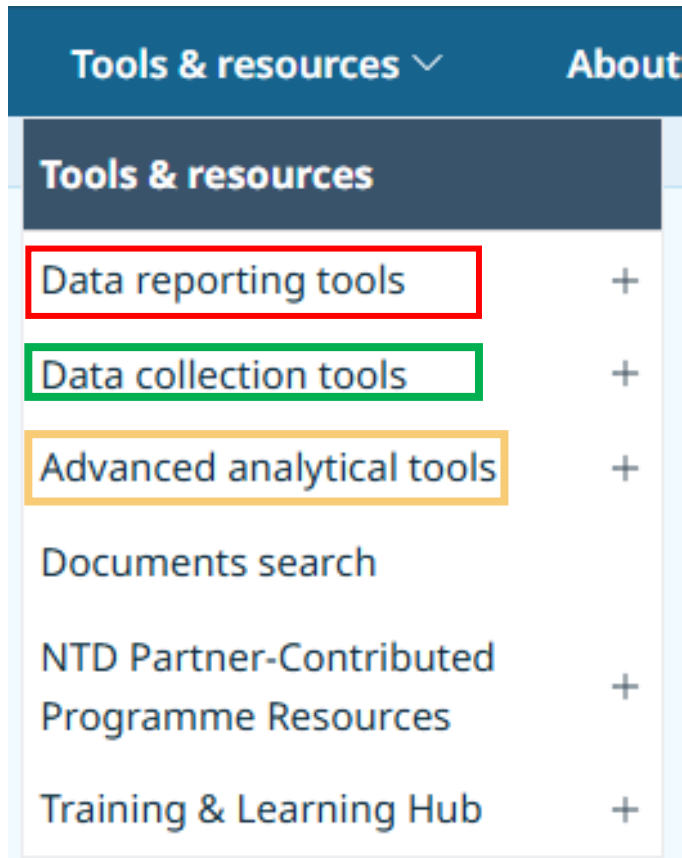
Trachoma is a neglected tropical disease. It is caused by infection with the bacterium *Chlamydia trachomatis*, which spreads from person to person through contaminated surfaces, fomites and flies that have come into contact with discharge from the eyes or nose of an infected person.

Environmental risk factors for trachoma transmission include poor hygiene, overcrowded households, and inadequate access to water and sanitation.

To eliminate trachoma as a public health problem, WHO recommends the SAFE strategy: a comprehensive approach to reduce transmission of the causative organism, clear existing infections and deal with their effects. The SAFE strategy consists of surgery to treat the blinding complication (trachomatous trichiasis), antibiotics to clear the infection, particularly mass drug administration of the antibiotic azithromycin (which has been donated by the manufacturer, Pfizer), to elimination programmes through the International Trachoma Initiative; facial cleanliness; and environmental improvement, particularly improving access to water and sanitation.

The road map for neglected tropical diseases 2021–2030 targets the prevention, control, elimination and eradication of 20 diseases and disease groups by 2030. Progress against trachoma and other neglected tropical diseases alleviates the human and economic burden that they impose on the world's most disadvantaged communities.

Tools & Resources – Technical Guidance at Your Fingertips



Joint Application Package (JAP) upload tool



JAP search

ESPEN Collect



ESPEN Collect Dashboard

Advanced Analytical tools:

- Country Health information Platform (CHIP)
- Schistosomiasis Mapper tool: SPPA protocol
- ESPEN Geospatial microplanner
- Implementation Unit Planner
- ESPEN GenAI Assistant

ESPEN GenAI Assistant



Opportunities – Engagement with the NTD Community

Annual Meetings of National NTD Programme Managers in the WHO Africa Region



Introduction

The Annual Meeting of National NTD Programme Managers in the WHO Africa Region stands as a testament to our collective resolve in the ongoing battle against Neglected Tropical Diseases (NTDs). In the face of unprecedented global challenges, these meetings have emerged as pivotal gatherings for sharing knowledge, aligning strategies, and reinforcing our commitment to public health and the Sustainable Development Goals.

Background and significance

The journey of the past few years, notably marked by the COVID-19 pandemic, has underscored the importance of resilience and adaptability in healthcare. The launch of the WHO NTD Roadmap 2021-2030 and the endorsement of various strategic frameworks, including the WHO/AFRO Tropical and Vector-borne Diseases (TVD) strategic framework and the WHO strategic framework for the integration of skin NTDs, have charted a new course for our collective efforts.

Remarkable strides have been made, with ten African countries eliminating specific NTDs and significant reductions in the number of individuals requiring NTD interventions. The achievement of Togo, becoming the first country globally to receive WHO validation for eliminating four NTDs, stands as a beacon of hope and possibility.

The need for Annual Meetings

These meetings are more than just a congregation of minds; they are a rallying point for action. The challenges of funding and resource allocation, especially in the wake of the pandemic, have brought to the fore the urgency of advocacy, innovative resource mobilization, and the criticality of country ownership. These gatherings serve as a platform for sharing best practices, technical updates, and fostering cross-sectoral collaborations, crucial for sustaining momentum and adapting to evolving public health landscapes.

Objectives and expected outcomes

The general objective of these meetings is to review progress, align national NTD Master Plans with the WHO NTD Roadmap, and foster stronger country ownership for accelerating programmatic action. Specific objectives include sharing experiences and challenges, providing technical and innovative updates, highlighting strategies for strengthening country ownership and supporting operational planning at the country level.

Expected outcomes encompass a shared understanding of the challenges and opportunities in NTD implementation, the adoption of strategies for effective coordination and collaboration, and the development of operational plans to close funding gaps and achieve regional targets.

The way forward

As we move forward, the focus on integration, structural support, and leveraging data analytical tools like the ESPEN portal becomes increasingly vital. The integration of NTDs with other communicable and non-communicable diseases under the UHC-CND framework is a strategic step towards achieving our goals.

The meetings, therefore, are not just annual events but milestones in our collective journey towards a world free from the scourge of NTDs. They represent our unified commitment to advancing public health, strengthening health systems, and making NTDs a thing of the past.

Annual meetings



15 to 17 April 2025
6th Annual meeting of
National NTD
Programme Managers
Lomé, Togo

Innovating for acceleration:
Pathways to NTD Elimination

Annual Meeting



29 November to 01 December
2023

5th Annual meeting of
National NTD
Programme Managers
Brazzaville, Republic of the
Congo

Stepping up country
ownership to accelerate
programmatic action

Annual Meeting

15 to 16 December 2021

4th Annual meeting of
National NTD
Programme Managers

Stepping into the decade of
NTDs elimination

Annual Meeting

07 to 11 December 2020

3rd Annual meeting of
National NTD
Programme Managers

NTD elimination, now more
than ever

Annual Meeting

The Mwele Malecela Mentorship Program for Women in NTDs

Purpose

The Mwele Malecela Mentorship (MMM) Program for Women in Neglected Tropical Diseases (NTDs) supports mid-career African women to become leaders and champions in NTD elimination at national and international levels. NTDs and other Tropical and Vector-Borne Diseases (TVD) Programmes are part of and contribute to the work of the Universal health coverage/Communicable and non-communicable diseases (UHC/UCN) cluster in the WHO African region.

WHO/AFRO is leading this program in collaboration with The END Fund and the American Society for Medicine, Hygiene and Tropical Medicine (ASMTM). Aligned with the Global NTD Roadmap, the MMM program will provide mentorship, training and networking opportunities over two years to cohorts of women from 2023 to 2030.



MMM Program Reports

PDF | 256.57KB

MMM Program Report August 2023

PDF | 422.87KB

MMM Program Report May 2023.pdf

PDF | 425.54KB

MMM Monthly Report February 2023.pdf

	January	February	March	April	May	June	July	August	September	October	November	December
Cohort Selection Mentee	Stage 1 application portal live			Stage 1 screening & Stage 2 Candidates Selection	Stage 2 applications		Selection Committee review process		Steering Committee approval of mentees selected	1. Selected mentees announced (ASTMH, NNN, online, etc.)	1. Matching is complete	1. Program kick off
Cohort Selection Mentor	Mentor applications open				Selection Committee review process					2. Mentium begins matching: Surveys shared with both mentees and mentors	2. Match check carried out	2. Announcements that next cohort applications open in January
					Non-selected applicants (mentees) notified				Non-selected applicants (mentees Stage II) notified		Unmatched mentors notified	
Year 1: Cohort Management (Standard for every month is one meeting with mentor)	Cohort Launch	Cohort Midpoint Review	Webinar	Networking Opportunity	Networking Opportunity	Webinar	Networking opportunity	Leadership Programme	Webinar	Networking Opportunity	Networking Opportunity	End of programme event
Year 2: Cohort Management (Standard for every month is one meeting with mentor)												

CLOSING – Wrap-Up & Key Messages

Wrap-up & Key Messages

- The ESPEN Portal is the central hub for PC-NTD data, supporting strategic planning and monitoring.
- Version 4.0 brings faster performance, multi-language access, and a new GenAI Assistant.
- Explore dashboards, maps, and downloadable datasets—customized by disease, region, and time.
- Use ESPEN tools for data collection (ESPEN Collect), reporting (JAP Upload), and advanced planning (e.g., IU Planner, Geospatial Microplanner).
- Engage with the Portal as a daily resource—not just for reports, but to guide action and track progress.

Your feedback is crucial—help us **improve and expand** these tools to better serve your programmes

Thank you for your attention



Thank you to all our partners

MRM: Manta Ray Media

SC: StandardCode

GET: Global Elimination Trachoma

IHME: Institute for Health Metrics & Evaluation

Sightsavers

Dimagi

London School of Hygiene & Tropical Medicine

Gates foundation

...and all country programmes and in-country partners submitting data to WHO/ESPEN

•THANK
•YOU



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



**TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING**
NTD Data Use, Reporting and Supply Chain
Capacity

Kintélé, Brazzaville,
Republic of the Congo

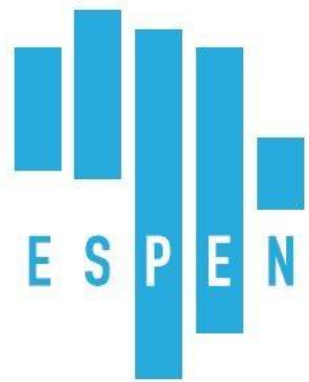
**Advances in Data and Analytics for
Sustaining NTD Elimination in
Africa - ESPEN Gen AI Assistant**



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

Advances in Data and Analytics for Sustaining NTD Elimination in Africa - ESPEN Gen AI Assistant

In collaboration with **dimagi**

Agenda

1. Background
 - a. Purpose
 - b. ESPEN Gen AI Assistant Workflow
 - c. Core Capabilities
2. How To Access ESPEN Gen AI Assistant
3. Sample Queries
4. Widget Features
5. User Guide

Background

ESPEN Portal: Rich repository of WHO guidelines, data, reports & maps

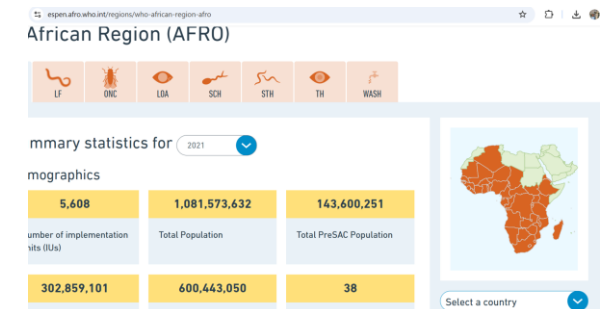
Challenge:

- Fragmented data access.
- Limited analytical capacity for decision-making.
- Time-consuming document searches.

Need: Increase engagement & usability of ESPEN data



SN	CONTINE	REGION	WHO_RE	ADMIN0	ADMIN0IC	ADMIN0_
1	Africa	Northern AAFRO	Algeria		1	AG
2	Africa	Northern AAFRO	Algeria		1	AG
3	Africa	Northern AAFRO	Algeria		1	AG
4	Africa	Northern AAFRO	Algeria		1	AG
5	Africa	Northern AAFRO	Algeria		1	AG
6	Africa	Northern AAFRO	Algeria		1	AG
7	Africa	Northern AAFRO	Algeria		1	AG
8	Africa	Northern AAFRO	Algeria		1	AG
9	Africa	Northern AAFRO	Algeria		1	AG
10	Africa	Northern AAFRO	Algeria		1	AG
11	Africa	Northern AAFRO	Algeria		1	AG
12	Africa	Northern AAFRO	Algeria		1	AG
13	Africa	Northern AAFRO	Algeria		1	AG
14	Africa	Northern AAFRO	Algeria		1	AG

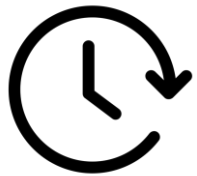


How can AI address these issues?

Purpose

NTD Programme Managers Face a Critical Information Bottleneck

When was the last time you needed some data for e.g. What is the history of MDA implementation for Schistosomiasis in Angola since 2013, including the number of implementation units each year -- and spent 15 minutes clicking through PDFs or spreadsheets?

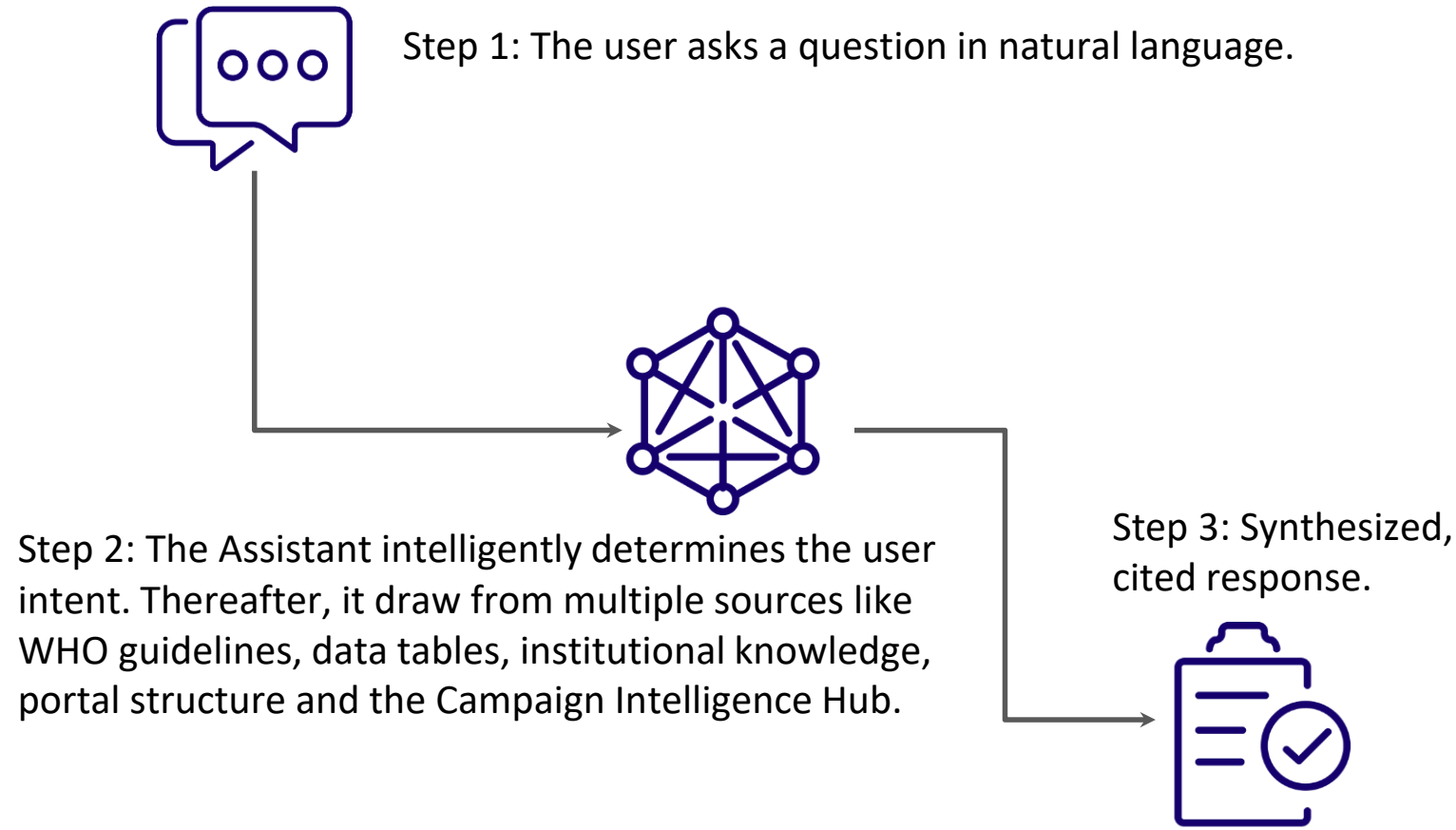


Finding the necessary information on the ESPEN Portal can be time-consuming and painful



This 'data friction' slows down critical analysis, reporting, and decision-making for national NTD programmes.

ESPEN Gen AI Assistant Workflow



The assistant intelligently determines the user's intent. It then queries multiple trusted data and knowledge sources simultaneously to deliver an accurate, cited answer.

Core Capabilities



Data Retrieval: Instantly query specific data points.



Trend Analysis: Generate trend visualizations over time.



Integrated Campaign Planning: Provide information for integrating campaigns by leveraging the Campaign Hub.



Document & Knowledge Synthesis: Summarize and explain complex topics from multiple official sources, such as WHO road maps and guidelines.

How To Access ESPEN Gen AI Assistant

1. Visit [ESPEN Website/Portal](#).

1. Click On **Ask Me** Icon on the bottom right corner (as shown in image)

The screenshot shows the ESPEN GenAI Assistant interface. At the top, there's a dark blue header with the ESPEN logo (Expanded Special Project for Elimination of Neglected Tropical Diseases) on the left, and navigation links for 'JAP Upload Tool', 'ESPEN Collect', 'English', and the 'World Health Organization African Region' on the right. Below this is a lighter blue navigation bar with links for 'Maps & data', 'Updates & Events', 'Opportunities & initiatives', 'Tools & resources', and 'About'. A breadcrumb trail indicates the current location: 'Tools & Resources / Advanced Analytical Tools / ESPEN GenAI Assistant'.

The main content area has a large yellow vertical bar on the left and the title 'ESPEN GenAI Assistant'. Below the title, a blue double exclamation mark icon is followed by the text: 'Welcome to the [GenAI ESPEN Assistant](#) chatbot built on [Open Chat Studio](#)!'. A section titled 'What it does?' explains that the assistant is built to help with data analytics and document navigation on the WHO ESPEN portal, providing responses in English, French, or Portuguese. It lists three capabilities: providing accurate answers on NTD-related queries, helping find reports, datasets, maps, and guidelines, and providing accurate answers on NTD-related queries.

On the right side, there's a 'GenAI Assistant Help' section with three PDF links: 'Guidelines for Using the ESPEN GenAI Assistant' (104.7KB), 'Lignes directrices pour l'utilisation de l'Assistant GenAI d'ESPEN' (112.55KB), and 'Diretrizes para o uso do Assistente GenAI da ESPEN' (112.87KB). At the bottom right, there's a yellow circular icon with a robot face and the text 'Ask me!'. A callout box points to this icon, stating: 'ESPEN GenAI Assistant is embedded on the ESPEN Portal!'.

Knowledge Query

“Under the WHO new LF M&E guidelines, what are the antigenemia and microfilaria thresholds for a sentinel site to pass an EMS survey?”

 $\oplus \quad \begin{smallmatrix} \swarrow & \searrow \\ \nearrow & \nwarrow \end{smallmatrix} \quad \rangle$

16:40

You can ask me questions such as:

- Please note: This assistant is currently in a test phase. We welcome your feedback. After your interaction, you can click "End Experiment" and complete the short form on the next page to share your thoughts.

Under the WHO new LF M&E guidelines, what are the antigenemia and microfilaremia thresholds for a sentinel site to pass an EMS survey?

Under the WHO LF monitoring and evaluation guidance, a sentinel site passes an EMS if antigenemia is below 2% or, when microfilaremia is assessed among Ag-positive people, microfilaremia is below 1% using the total population tested for Ag as the denominator. If Ag is 2% or higher, or Mf is 1% or higher, the site is above threshold and additional MDA is recommended; if Mf cannot be measured, Ag alone can be used and programmes should continue MDA when Ag is 2% or higher.

[M&E Assessment Of MDA In The Global Programme To Eliminate Lymphatic Filariasis A Manual For National Elimination Programmes.pdf](#) (pg. 25,30–31)

If you'd like, I can also summarize the full EMS decision rule: or compare EMS with TAS/IIS thresholds.

[M&E Assessment Of MDA In The Global Programme To Eliminate Lymphatic Filariasis A Manual For National Elimination Programmes.pdf](#)

16:45

Send message

Sample Queries

Data Query

“What is Program coverage trends for the past 5 years in Nigeria for LF”

“Please generate the Line chart with Annotation for the same ”

• How many people were treated for STH in Mozambique in 2022?

Please note: This assistant is currently in a test phase. We welcome your feedback. After your interaction, you can click “End Experiment” and complete the short form on the next page to share your thoughts.

16:48

What is Program coverage trends for the past 5 years in Nigeria for LF

16:51

Nigeria's LF programme coverage stayed high over 2021–2024, rising overall from 91.54% in 2021 to a peak of 97.63% in 2024 after a dip to 88.58% in 2022; the 2025 row currently shows 0.0%, based on the country LF indicators data available in the ESPEN database.

Year	Programme coverage
2021	91.54%
2022	88.58%
2023	92.30%
2024	97.63%
2025	0.00%

If you'd like, I can also show this as a simple trend graph. Or I can compare Nigeria's LF programme coverage with another country or earlier years.

16:52

Please generate the Line chart with Annotation for the same

16:54

Nigeria's LF programme coverage was high from 2021 to 2024, increasing overall from 91.54% in 2021 to a peak of 97.63% in 2024, while the 2025 row shows 0.0%; the data also indicate that the JRF was not submitted for 2025, based on the country LF indicators data available in the ESPEN database.

Year	Programme coverage
2021	91.54%
2022	88.58%
2023	92.30%
2024	97.63%
2025	0.00%

Here is the line chart with annotation: [Download the graph](#) [Click here to download the Graph](#)

If you'd like, I can also compare this trend with Nigeria's national coverage. Or I can create the same chart for another country or a different five-year period.



16:55

Sample Queries

Campaign Query

“Show me the upcoming campaigns for LF in Nigeria?”

⋮

Hello

17:10

Hi, I am the ESPEN AI Assistant, capable of providing accurate NTD-related insights. I can retrieve reports, explain data visualizations, and perform trend analysis based on available data for Neglected Tropical Diseases (NTDs) such as lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminths, and trachoma. I can answer FAQs based on available information and provide structured results with authoritative citations. I support multiple languages: English, French, and Portuguese.

You can ask me questions such as:

- What is the current status of mass drug administration (MDA) for schistosomiasis in Nigeria?
- Can you provide the latest data on trachoma elimination progress in Ethiopia?
- How many people were treated for STH in Mozambique in 2022?

Please note: This assistant is currently in a test phase. We welcome your feedback. After your interaction, you can click “End Experiment” and complete the short form on the next page to share your thoughts.

17:11

Show me the upcoming campaigns for LF in Nigeria?

17:11

Here are the upcoming LF campaigns I found for Nigeria, based on campaign data available through the Health Campaign Effectiveness Coalition database.

Year	Scope	Activity	Areas targeted	People targeted	Status
2026	Subnational	MDA	Akwa Ibom, Bauchi, Bayelsa, Benue, Cross River, Delta, Ebonyi, Edo, Enugu, FCT, Gombe, Imo, Jigawa, Kaduna, Kano, Kebbi, Kogi, Kwara, Lagos, Niger, Ogun, Ondo, Osun, Oyo, Rivers, Sokoto, Taraba, Yobe, Zamfara	—	Unknown
2027	National	MDA	Nigeria	181,598	Unknown
2027	National	MDA	Nigeria	69,251	Unknown
2027	National	MDA	Nigeria	87,167	Unknown
2028	National	MDA	Nigeria	71,042	Unknown
2028	National	MDA	Nigeria	89,421	Unknown
2029	National	MDA	Nigeria	72,879	Unknown
2029	National	MDA	Nigeria	91,733	Unknown
2030	National	MDA	Nigeria	74,764	Unknown
2030	National	MDA	Nigeria	94,105	Unknown

What else can I help with? If you'd like, I can compare these with another country, or show only the campaigns for one specific year.

17:12

Type a message...

Send message

Powered by [Dimagi](#)

Widget Features

The screenshot displays the ESPEN Portal website. The main banner features the title "Accelerating elimination of NTDs - Towards 2030" and a description: "The ESPEN Portal enables health ministries and stakeholders to share, and exchange subnational programme data, in support of the NTD control and elimination goals." Below the banner is a statistics section with six data points. A chat widget is overlaid on the right side, with callouts explaining its features: "Click and hold here to drag the widget" (pointing to the top-left corner), "Click here to Start a New Chat" (pointing to the top-right corner), and "Click here to expand the widget Size" (pointing to the maximize button).

Maps & data ▾ **Updates & Events** ▾ **Opportunities & Initiatives** ▾ **Tools & resources** ▾ **About** ▾ 🔍

Accelerating elimination of NTDs - Towards 2030

The ESPEN Portal enables health ministries and stakeholders to share, and exchange subnational programme data, in support of the NTD control and elimination goals.

1.4 billion people affected by NTDs worldwide

39% of the global burden occurs in Africa

518.6 million people for PC-NTD

8 countries have eliminated at least 1 PC-NTD in the African region

61.3% reduction population requiring MDA for lymphatic filariasis in Africa

289 million received treatment for PC-NTD in 2022

Hi, I am the ESPEN AI Assistant, capable of providing accurate NTD-related insights. I can retrieve reports, explain data visualizations, and perform trend analysis based on available data for Neglected Tropical Diseases (NTDs) such as lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminths, and trachoma. I can answer FAQs based on available information and provide structured results with authoritative citations. I support multiple languages: English, French, and Portuguese.

You can ask me questions such as:

- What is the current status of mass drug administration (MDA) for schistosomiasis in Nigeria?
- Can you provide the latest data on trachoma elimination progress in Ethiopia?
- How many people were treated for STH in Mozambique in 2022?

Please note: This assistant is currently in a test phase. We welcome your feedback. After your interaction, you can click "End Experiment" and complete the short form on the next page to share your thoughts.

Type a message... Send message

Powered by [Dimagi](#)

Ask me!

User Guide

1. Visit [ESPEN Website/Portal](#).

1. Click On **Tools & Resources** and Select **Advanced analytical tools** and Click on **ESPEN GenAI Assistant** to access the User guide to know more

The screenshot shows the ESPEN GenAI Assistant page. The header includes the ESPEN logo (FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES) and the Organization African Region. The navigation bar has links for Maps & data, Updates & Events, Opportunities & Initiatives, Tools & resources, and About. The breadcrumb trail is: Tools & Resources / Advanced Analytical Tools / ESPEN GenAI Assistant.

ESPEN GenAI Assistant

Welcome to the [GenAI ESPEN Assistant](#) chatbot built on [Open Chat Studio](#)!

What it does?

The [ESPEN GenAI Assistant](#) is built to help you with data analytics and navigate documents on the WHO ESPEN portal. Upon receiving your query, the chatbot searches through its existing repository of resources pulled from the existing ESPEN Portal to provide you with a response IN English, French, or Portuguese. The chatbot can help you in the following ways:

- **Provide accurate, up-to-date answers on NTD-related queries** using a set of documents uploaded from the ESPEN and other WHO-recommended sites.
- **Help find reports, datasets, maps, and guidelines** on the ESPEN portal.
- **Run SQL queries to generate insights from ESPEN data tables**, such as trends in disease cases and treatment coverage.
- **Display structured query results as tables, summaries, charts**, or downloadable CSV files.

How it works?

The chatbot is **NOT** a human. This chatbot does not “think” or “understand” things like a person. Instead, it

Tools & resources

- Data reporting tools +
- Data collection tools +
- Advanced analytical tools +**
- Documents search
- NTD Partner-Contributed Programme Resources +
- Training & Learning Hub +

Advanced analytical tools

- Country Health Information Platform (CHIP)
- ESPEN Geospatial Microplanner
- Schistosomiasis Mapper Tool
- Implementation Unit Planner
- ESPEN GenAI Assistant**

[PDF | 104.7KB](#)
Guidelines for Using the ESPEN GenAI Assistant

[PDF | 112.55KB](#)
Lignes directrices pour l'utilisation de l'Assistant GenAI d'ESPEN

[PDF | 112.87KB](#)
Diretrizes para o uso do Assistente GenAI da ESPEN

dimagi

• **THANK**
• **YOU**



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING
NTD Data Use, Reporting and Supply Chain
Capacity

Kintélé, Brazzaville,
Republic of the Congo

AI Fundamentals
for NTD Programs

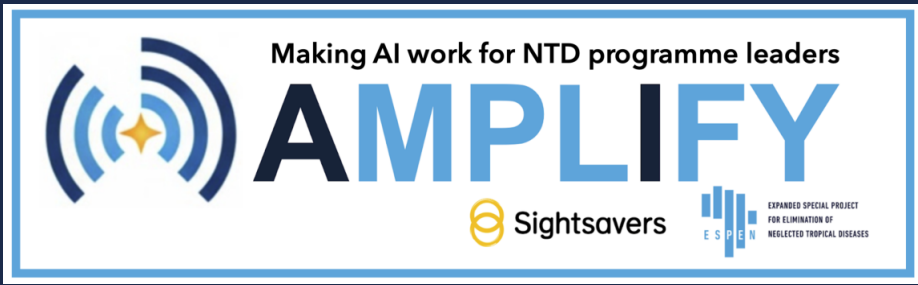
Alex Pavluck, Sightsavers
Honorat Zouré, ESPEN



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



Sightsavers × ESPEN

MODULE 1

AI Fundamentals for NTD Programs

Ethics, Governance, Data Protection
& Responsible Use

March 2026 | Session 1 of 7



Today's Agenda



Part 1: Introduction and Overview

Meet your instructors and cohort, course expectations and tools for the course



Part 2: Ethics, Governance & Data Protection

Red lines, bias, hallucinations, responsible use practices



Part 3: Demystifying AI

What AI is, where it exists in your work, strengths & limitations



Part 4: The Art of the Perfect Prompt

Hands-on prompting practice with NTD-relevant tasks



PART 1

Introduction & Overview

Meet your instructors and cohort, course expectations and tools for the course

Meet Your Instructors



Alex

Amplify instructor
(English)

Sightsavers



Geordie

Amplify instructor
(English & French)

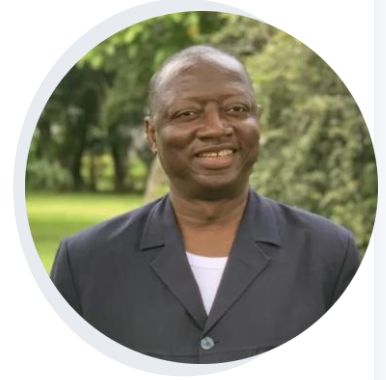
Sightsavers



Leah

Amplify instructor
(English)

Sightsavers



Zoure

Amplify instructor
(English & French)

WHO ESPEN

Meet Your Fellow Participants

18 NTD professionals from 8 countries across Africa

Cote d'Ivoire

Gabe Anicet
Hahyat N'Goran

Burkina Faso

Mamadou Serme

Togo

Gbandi Fare -Tassa Tchedre
Jean Tahaka Ahourma

DR Congo

Papy Bope Kwete
Dieu Merci Dwe Mupana
Samuel Lukanga
Elia Muhima

Ghana

Jones Anim
Michael Mensah Dzokoto
Rachel Aniniwaa Addo

South Sudan

Akoj Deng
Manyang Amos

Ethiopia

Fitsum Abraham Adalo
Gedefaw Liben
Tesfahun Bishaw

Zambia

Levison Nkoma

 Francophone

 Anglophone

What we hope you will get out of this class

Knowledge

How to use AI tools and services:

- as a **thinking/teaching partner**
- to support **knowledge management**
- to improve **presentations & training**
- to support **data cleaning and analysis**
- to produce **data visualizations**

Experience

- AI is a "***learning through doing***" field, the course will give you opportunities to apply course concepts to your own work so you can see the day-to-day impact
- Your **knowledge and experience can be a force multiplier for your team**, accelerating the effectiveness, efficiency, and capabilities of individuals and the MOH

Tools you will need for the course

AI Tools You Can Use

All have free tiers. Choose any for exercises and homework.

ChatGPT

OpenAI

chat.openai.com

Most widely used. GPT-4o free tier available.

Claude

Anthropic

claude.ai

Strong for long documents and nuanced writing. Good for software development.

Gemini

Google

gemini.google.com

Integrated with Google Workspace. Good for data.

Minstral AI

Minstral

chat.mistral.ai/chat

Mistral is a French artificial intelligence company that develops largely open-source large language models.



PART 2

Ethics, Governance & Data Protection

Using AI responsibly in public health programs

AI Risk: Hallucinations

What is a Hallucination?

AI confidently generates fabricated information:

Fake citations that look real but do not exist

Invented statistics with plausible numbers

False claims about guidelines or policies

How to Detect & Prevent

- Always verify citations - look them up
- Cross-check statistics with original sources
- Ask the AI to provide its sources
- Be skeptical of very specific numbers
- Use AI as a starting point, not the final word
- Never submit AI output as fact without verification

Critical Red Lines: What NEVER Goes Into AI



Patient Data (PII)

Full names, addresses, phone numbers, identifiable health records



Confidential Gov Data

Internal strategy documents, unpublished policy drafts



Unpublished Research

Pre-publication data, embargoed findings, proprietary datasets



Medical Records

Diagnoses, treatment histories, insurance details



Digital Credentials

Passwords, API keys, encryption keys, login credentials



Financial Information

Bank details, credit cards, confidential budget allocations

Data entered into public AI tools may be stored, used for training, or accessed by third parties. Always use de-identified data.



Balancing Innovation with Caution

AI Strengths

- Summarize & translate
- Automate repetitive work
- Pattern recognition
- Draft generation
- Multi-source synthesis

AI Risks

- No contextual understanding
- Hallucinations
- Data privacy risks
- Bias amplification
- Over-reliance

Discuss: How can you be an AI leader in your organization?
How do you promote the benefits while protecting against the risks?



PART 3

Demystifying AI

What AI is (and isn't) and how it can support your NTD work

Key Terms You Need to Know

Prompt

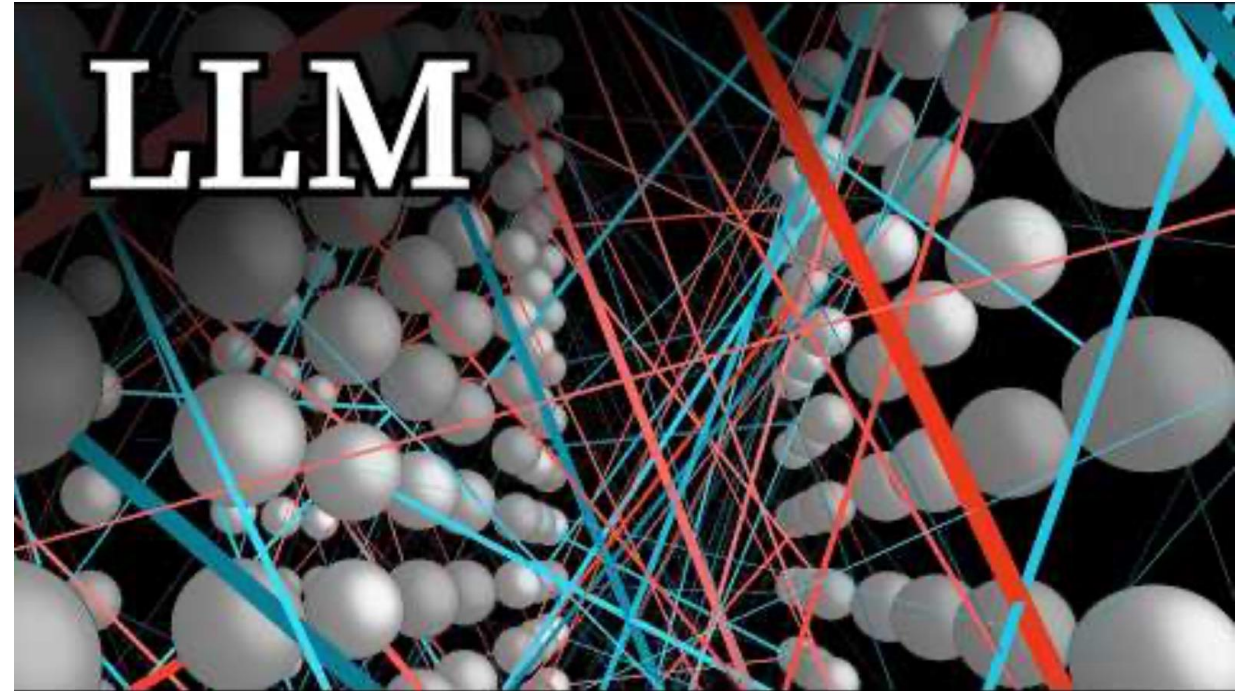
The text or instructions you give to an AI model telling it what to do.

Hallucination

When AI generates confident-sounding but incorrect or fabricated information.

Large Language Model (LLM)

An artificial intelligence system trained on vast amounts of text so it can understand prompts and generate coherent, human-like language.



Key Terms You Need to Know

Natural language Processing (NLP)

Field of AI that allows computers to understand, produce, and communicate in human languages such as English or French.

Generative AI

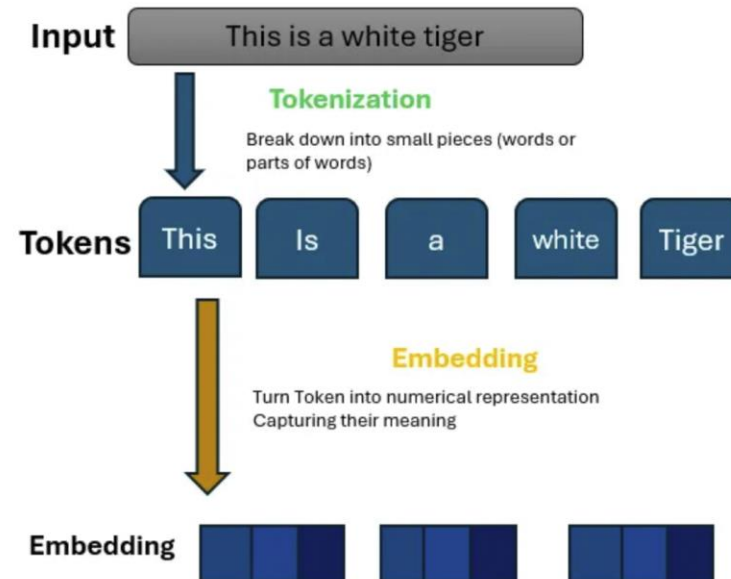
A type of artificial intelligence that learns patterns from existing data to create new, original content such as text, images, audio, or video in response to user prompts.

Token

A small unit of text (word, sub-word) that language models use as basic units.

Bias

Systematic errors from biased training data leading to unequal treatment of groups.



What to know more?

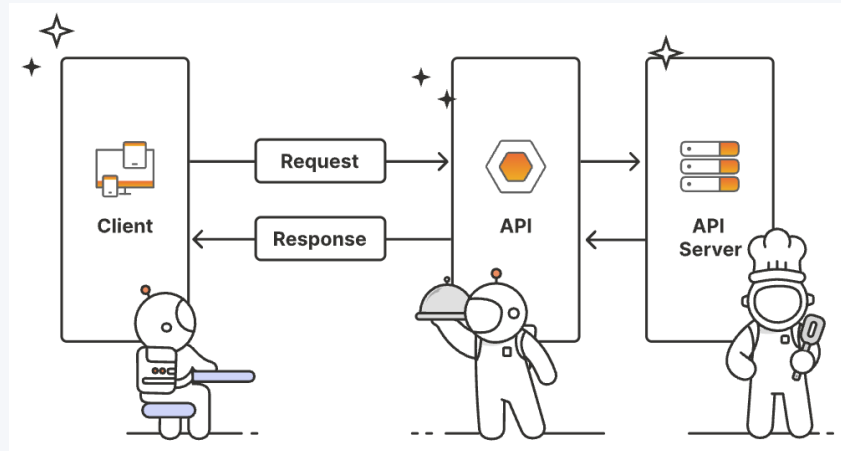
Source: Medium
[LLM building blocks - Tokens and Embeddings](#)

Language models deal with text in small chunks called tokens. To compute language, the language model needs to turn tokens into numeric representations called embeddings.

Key Terms You Need to Know

API (Application Programming Interface)

A standard way for software systems to communicate; many AI models are accessed via APIs so applications can send prompts and receive outputs.

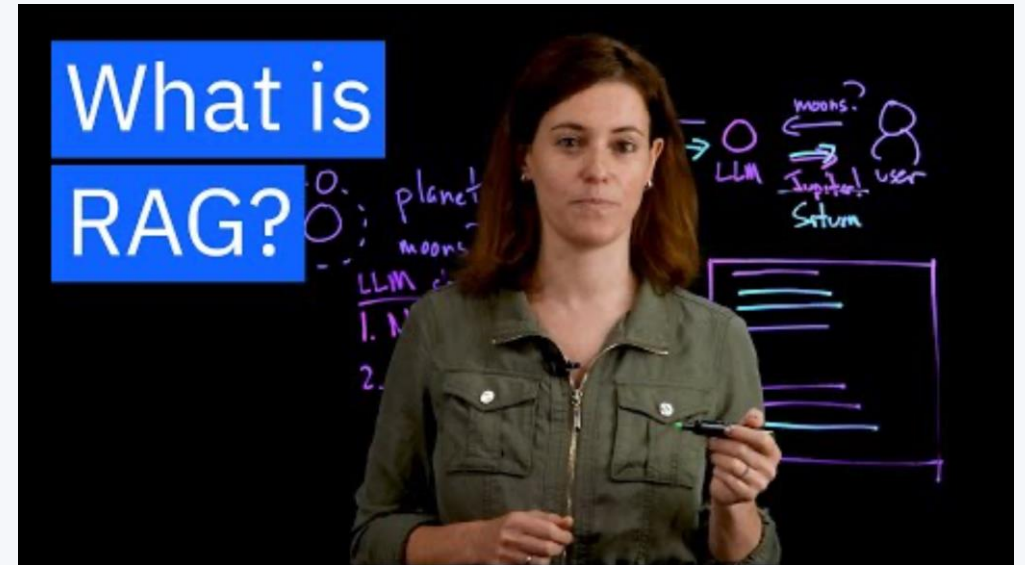


Learn more about APIs:

<https://www.postman.com/what-is-an-api/>

RAG Model (Retrieval-Augmented Generation)

An AI framework that enhances Large Language Models (LLMs) by retrieving information from a trusted knowledge base, such as company documents or databases, before generating a response.



AI Tools Already in Your Work

You may already be using AI without realizing it

Translation Services

Microsoft Office, WhatsApp, Google Translate

Customer support

Ask questions and generate responses

Email & Spam Filters

Classifies messages and detects spam

ESPEN GenAI Assistant

AI-powered Q&A tool for NTD program data (Dimagi)

NotebookLM

ESPEN Collect & Lymphedema training

Predictive Text

Phone keyboards, autocomplete — powered by language models

Discussion: Where else might AI tools be operating in your program?

What Generative AI Do Well



Process & summarize text

Summarize a 50-page WHO guideline in minutes



Translation across languages

Translate MDA reports between French and English



Automate repetitive tasks

Format data tables, draft routine emails



Identify patterns in data

Spot trends in prevalence data across years



Combine multiple sources

Synthesize findings from several survey reports



Draft and generate content

Create first drafts of proposals, training materials

Generative AI's Critical Limitations



Lacks contextual understanding

Answers based on probability, NOT true understanding of your program context



Hallucinations

AI can confidently generate false citations, statistics, and facts



False sense of accuracy

Speed and fluency create over-reliance; polished text is not correct text



Data privacy risks

Information in public AI tools may be stored or used for training



Bias amplification

Training data contains biases that models can reproduce and amplify



Cannot self-verify

AI cannot fact-check itself; human review is always required

Generative AI goes beyond the chatbot



Agentic browsers

Generative AI models that can take actions using the browser



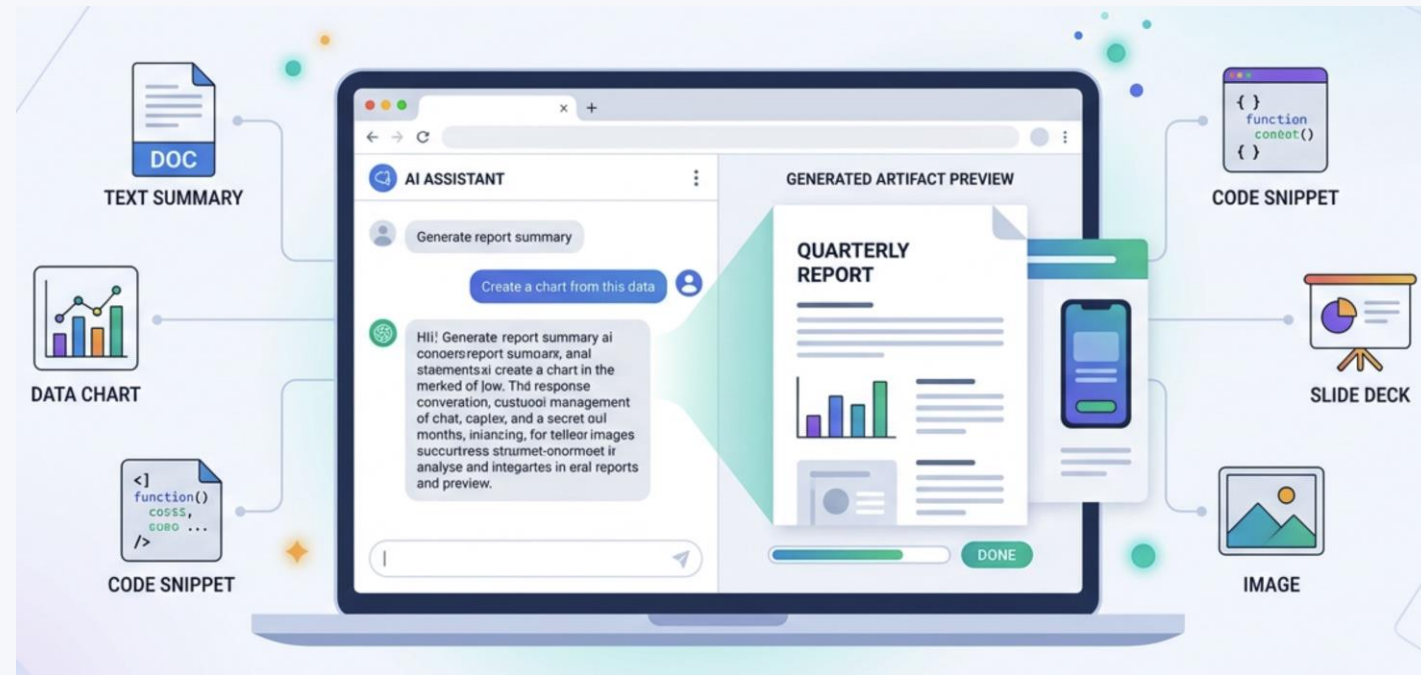
AI Artifacts

Original images, audio, office documents, websites, and much more



Coding assistance

AI tools that work in software development IDEs



We will cover these tools and use cases in future modules!



PART 4

The Art of the Perfect Prompt

Communicating with AI to get what you need



Chatbots: How to use them as a thinking partner

We will discuss how to structure prompts; here are just some high-level approaches to consider

When you need help with something complex

“...think through this with me step-by-step” or “...break this down into smaller steps”

Transform results that are too vague

“That is helpful, but I need ideas specifically related to <your exact context>”

Socratic teaching (discover knowledge through reasoning)

“Ask questions to help me clarify my goals, surface assumptions, and weigh trade-offs. Do not decide for me”

Discussion: What are some other ideas on how you can use Chatbots as a thinking partner?

Why Prompting Matters



AI does not read your mind.

The quality of your output depends entirely on the quality of your input.

A vague question → a vague, generic answer

A specific, structured prompt → a focused, useful answer

Think of AI like a new, capable colleague who needs clear direction.

"The beginning of wisdom is the definition of the terms"

— Socrates

In this course, we will practice building prompts that are clear, contextualized, and designed for the real work you do in NTD programs.

The Prompt Framework: P-T-C-F-I



PERSONA

Tell the AI what expert perspective to adopt

Who is asking?



TASK

State clearly what you want done: summarize, write, compare...

What to do?



CONTEXT

Provide background: audience, purpose, constraints

Why & for whom?



FORMAT

Specify structure and tone: bullets, table, formal, simple..

How should it look?



ITERATE

Evaluate the output and refine. Good prompting is iterative.

Is it right yet?

Prompt Framework in Action: P-T-C-F-I

Color-coded example using a real NTD task:

You are a NTD M&E officer. You want to show the progress of the LF programme over the past 5 years. You have data on baseline endemicity, MDA rounds by IU, coverage by IU and round, and total rounds with effective coverage. Produce a table showing this in an easy-to-read format and a dataset for a map. Before finalizing, double check IU counts are consistent across years.



Persona- Who is asking?



Task- What to do?



Context- Why and for whom?



Format- How should it look



Iterate- Is it right yet?



Could this be improved? "Produce a table in an easy-to-read format" is still vague. What specific columns would you include?



Build Your First NTD Prompt

Using the framework, write a prompt for the task. Spend 5 minutes each writing your own prompt and use an AI software of choice. Then compare prompts and outputs within your group. Identify one person to share your discussions/reflections back in the main group.

Create a summary explaining what PC-NTDs are to a non-technical audience

Template: Persona ____ | Task ____ | Context ____ | Format ____

Welcome Back!

Reflection on Module 1 Homework



Discussion Questions

- What surprised you about using AI tools for the first time?
- Which P-T-C-F-I element made the biggest difference in your output?
- What was the hardest part of the homework?



Key Takeaways from Module 1

- AI is a tool, not a replacement for expertise
- Never enter PII or confidential data
- Structured prompts produce better results
- Always verify AI outputs

Ice Breaker: Share one way you used (or tried to use) AI since Module 1

Additional Resources

Written materials

[https://github.com/aishwaryanr/awesome-generative-ai-guide/blob/main/free courses/Applied LLMs Mastery 2024/week1 part1 foundations.md](https://github.com/aishwaryanr/awesome-generative-ai-guide/blob/main/free%20courses/Applied%20LLMs%20Mastery%202024/week1%20part1_foundations.md)

<https://medium.com/data-science-at-microsoft/how-large-language-models-work-91c362f5b78f>

Video materials

<https://youtu.be/5sLYAQS9sWQ?si=UjzsN6XKPWsQG3Y>

<https://youtu.be/LAF-IACf2QY?si=eEWNTtoTgmXJ9oFv>

<https://www.youtube.com/watch?v=T-D1OfcDW1M&t=215s>

Online courses

<https://www.deeplearning.ai/courses/ai-for-everyone/>

<https://www.coursera.org/learn/generative-ai-prompt-engineering-for-everyone>

Additional Resources

WHO Ethics & Governance of AI for Health

who.int/publications — Framework for responsible AI in health (2021)

Gemini NotebookLM

notebooklm.google.com — AI tool for document synthesis

OpenAI ChatGPT

chat.openai.com — General-purpose AI assistant

DIAL Digital Principles

digitalprinciples.org — Responsible technology use

ESPEN Portal

espen.afro.who.int — NTD data, maps, program tracking

Anthropic Claude

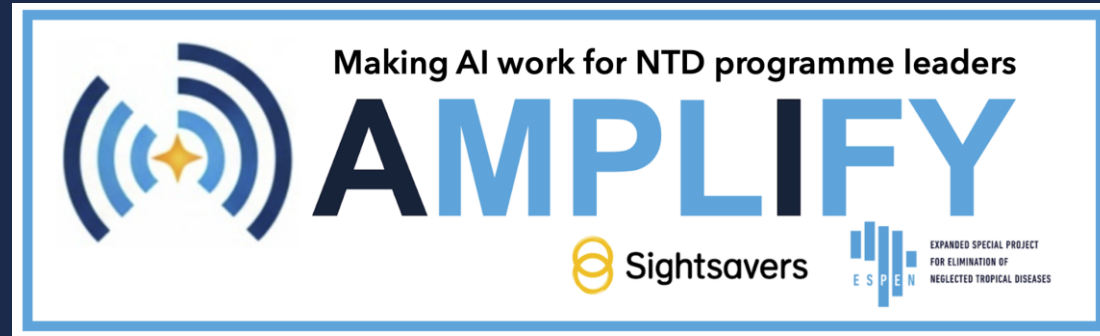
claude.ai — AI assistant for document analysis

PATH AI for Global Health

path.org/resources — AI guides for LMIC health systems

Prompt Engineering Guide

promptingguide.ai — Comprehensive prompting techniques



Thank You!

Module 1: AI Fundamentals for NTD Programs

• **THANK**
• **YOU**



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING
NTD Data Use, Reporting and Supply Chain
Capacity

Kintélé, Brazzaville,
Republic of the Congo

DAY 2



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

Using the Schistosomiasis Community Data Workbook

TRAINING WORKSHOP ON EFFECTIVE PC-NTDs DATA
PROCESSING AND USE FOR ENGLISH-SPEAKING
COUNTRIES

Kintélé International Conference Centre, Brazzaville (Congo)

24 to 28 August 2026
Presenter: Dr Jorge Cano

ESPEN Surveillance Officer



World Health
Organization



HEALTH
FOR ALL

Overview

A practical orientation: what to enter, what to check, and how to interpret outputs

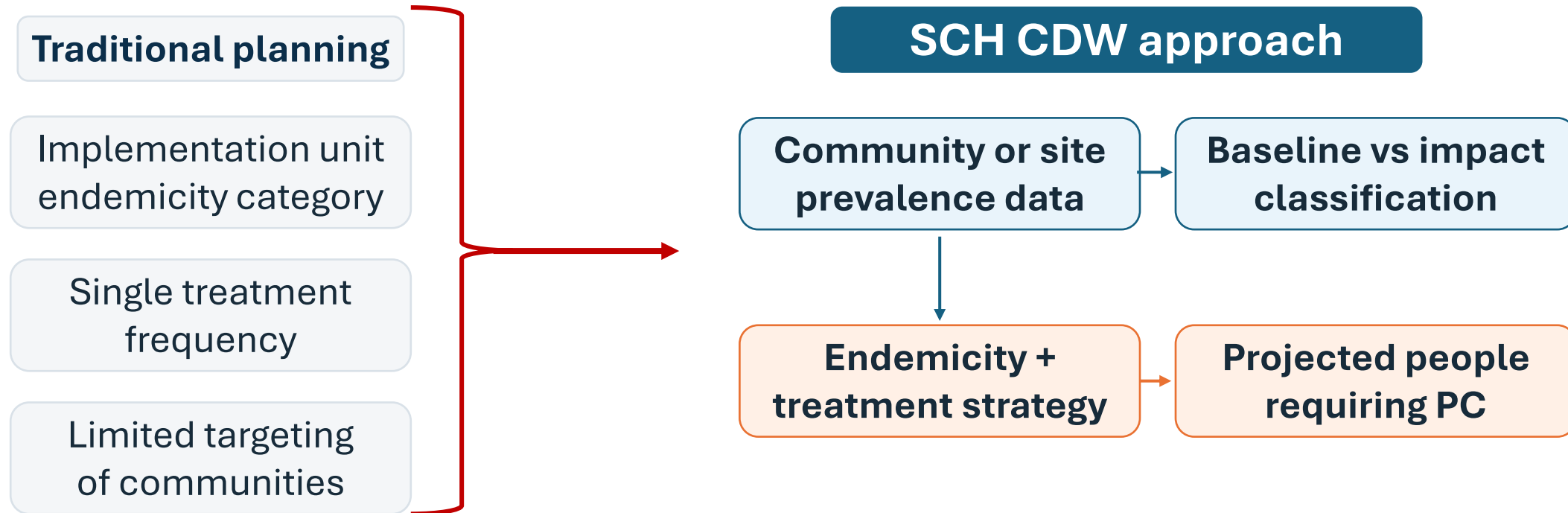
- 1 Why the CDW matters**
- 2 Structure & inputs**
- 3 Calculation logic**
- 4 Outputs & planning**
- 5 SCH CDW v6 in numbers**

By the end, participants should be able to:

- identify the workbook sheets that matter for planning
- recognize the required demographic, epidemiological and PC-history inputs
- explain how baseline / impact data feed endemicity stratification
- use outputs to validate JRSM requests and multi-year planning assumptions

Why the SCH CDW exists

From district-level assumptions to community-level programme decisions



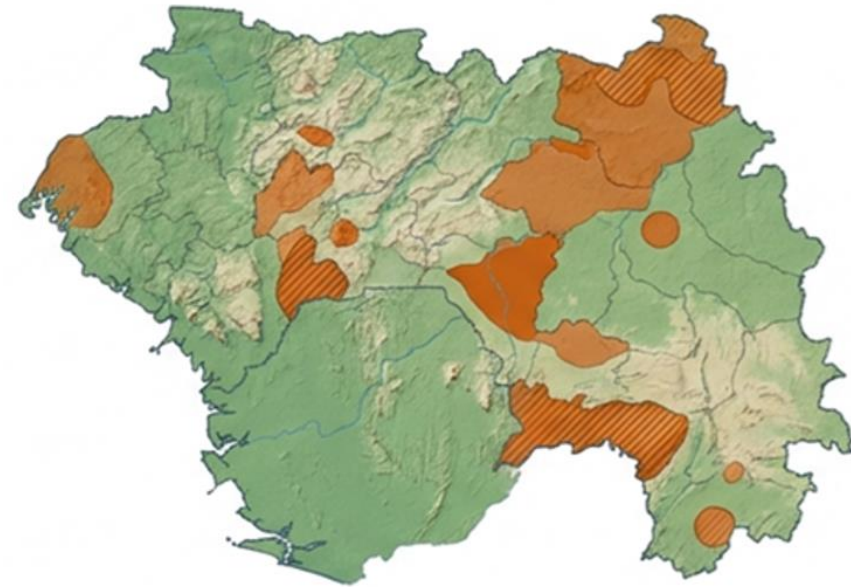
The workbook is not just a data repository. It is a decision engine for precision planning.

SCH Focality Requires Precision at the Sub-District Level



Masked Heterogeneity

Aggregated district-level estimates hide residual hotspots, directly risking programmatic over- or under-treatment.



Precision Targeting

Environmental and behavioral factors create extreme risk variations within specific communities.



Targeted Interventions

WHO guidelines strictly mandate fine-scale mapping to optimize Mass Drug Administration (MDA) deployments.



Transitioning to Elimination

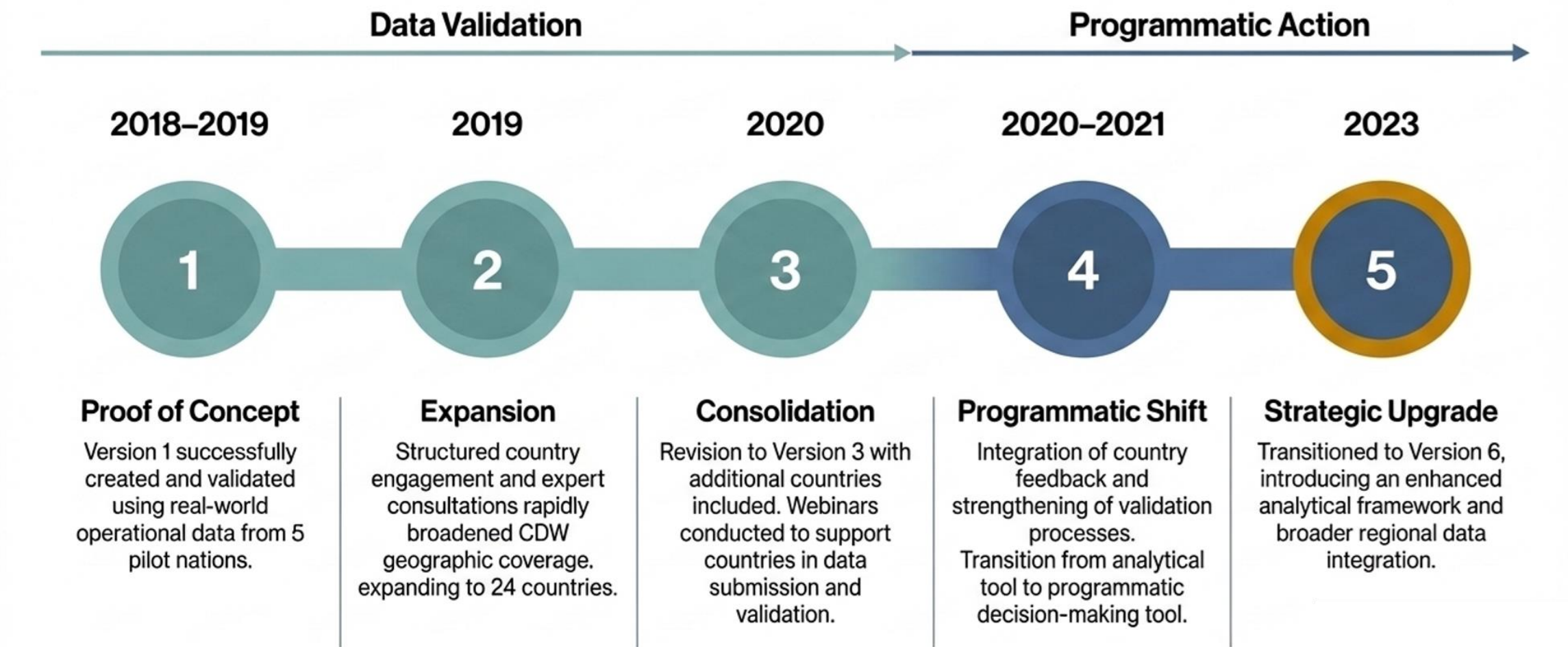
Granular, sub-IU data is a prerequisite for evidence-based decisions on scaling down or stopping MDA.



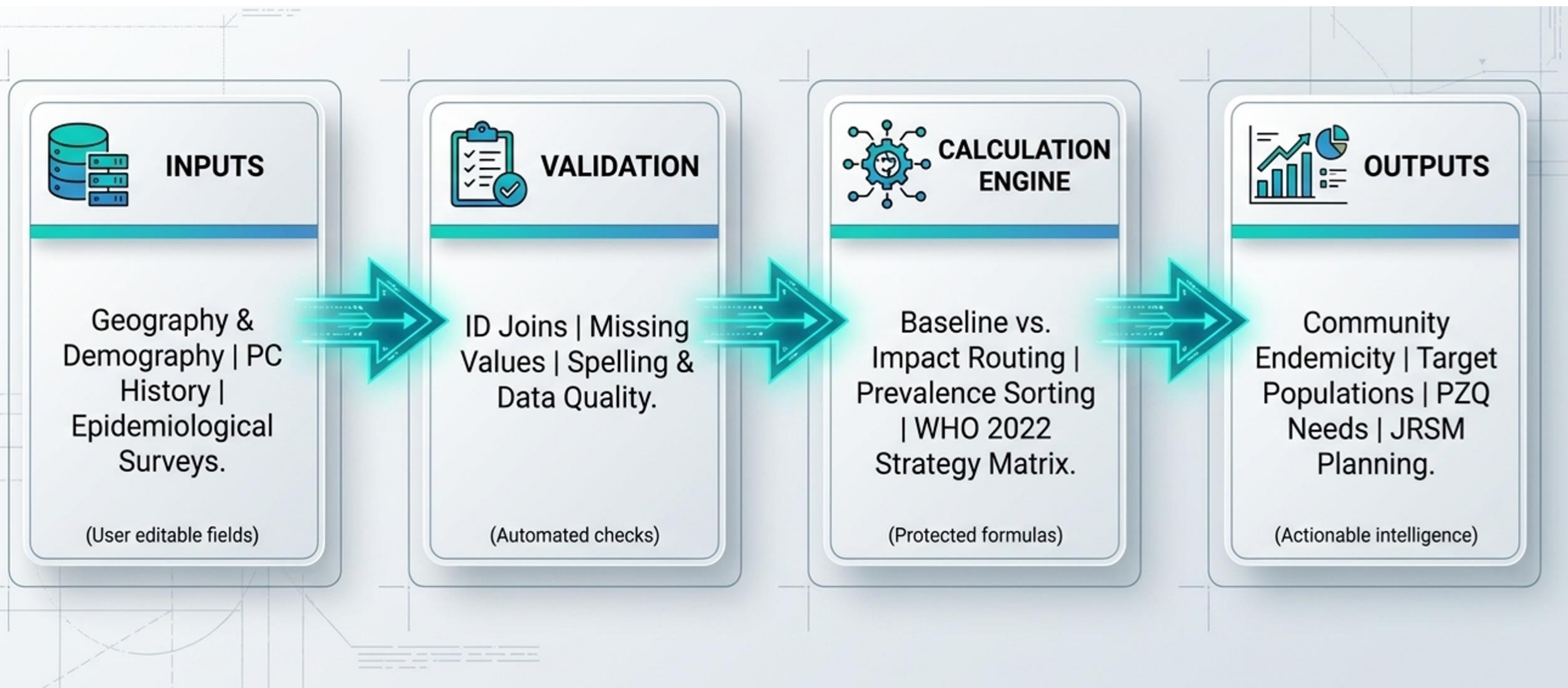
The CDW Solution

The SCH Community Data Workbook was engineered specifically to bridge this sub-IU intelligence gap.

From Proof of Concept to Strategic Decision Engine



Workbook architecture: what happens where



Input layer: what data managers must provide & verify

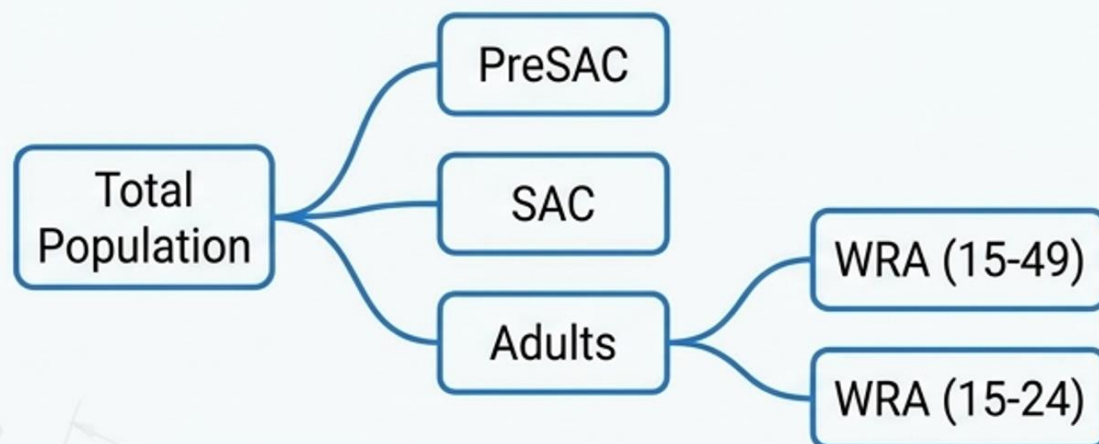
Sheet	Main purpose	Key fields to check	Eritrea example
IU_Data	IU-level PC summary and most recent JRSM endemicity	IU ID, population, JRSM endemicity, first/latest PC year, effective rounds	58 IU rows
demo_data	Community (sub-IU) population and PC history	Community ID, population year, PreSAC/SAC/adult/WRA groups, risk level, PC rounds	312 community rows
epi_data	Site-level epidemiological evidence	Community ID, site, coordinates, survey type, examined/positive, diagnostic, year, species	797 survey-site rows

Validation principle

Every epidemiological row must link to the correct community and IU. Most output errors start with broken IDs, inconsistent names, missing survey type, or incomplete PC history.

Input layer: Demographics (*sub-IU*)

Demographic Anchors



The Join Key: The Community ID [XXX-XXXXX-XXX] is the structural anchor that joins all sheets together.

Denominators: Total population adjusted for PreSAC, SAC, Adults, and Women of Reproductive Age (WRA 15-49 & 15-24).

Programmatic History



First Year of MDA: The algorithm cannot function without this.



Effective PC Rounds: Required to justify strategy de-escalation or highlight impact assessment gaps.

Input layer: Survey data (*site level*)

One row per site / diagnostic / survey event, with enough metadata to reproduce the decision

Community	Survey type	Diagnostic	Prev.	Year	Risk
Sub-IU 01	Baseline	Urine filtration	23.5%	2018	Moderate
Sub-IU 02	Impact	Kato-Katz	4.2%	2023	Low
Sub-IU 03	Baseline	CCA	0.0%	2019	Non-endemic

Minimum fields

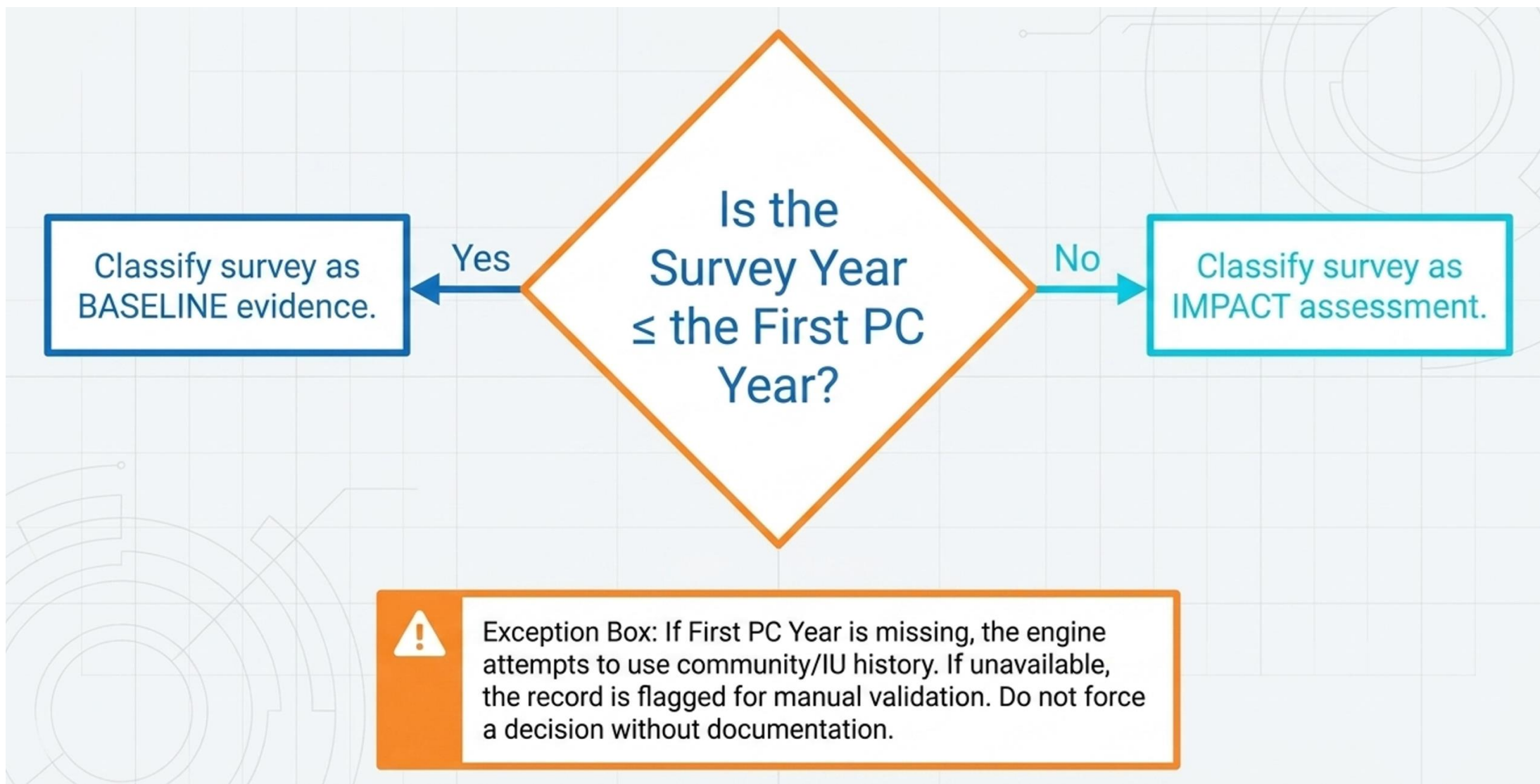
- community / site / coordinates
- examined and positive
- prevalence
- diagnostic method and type
- year of survey
- Schistosoma species or type
- survey type, source
- Quality (*calculated*)

Prevalence should be calculated from counts:
 $\text{positive} \div \text{examined} \times 100$

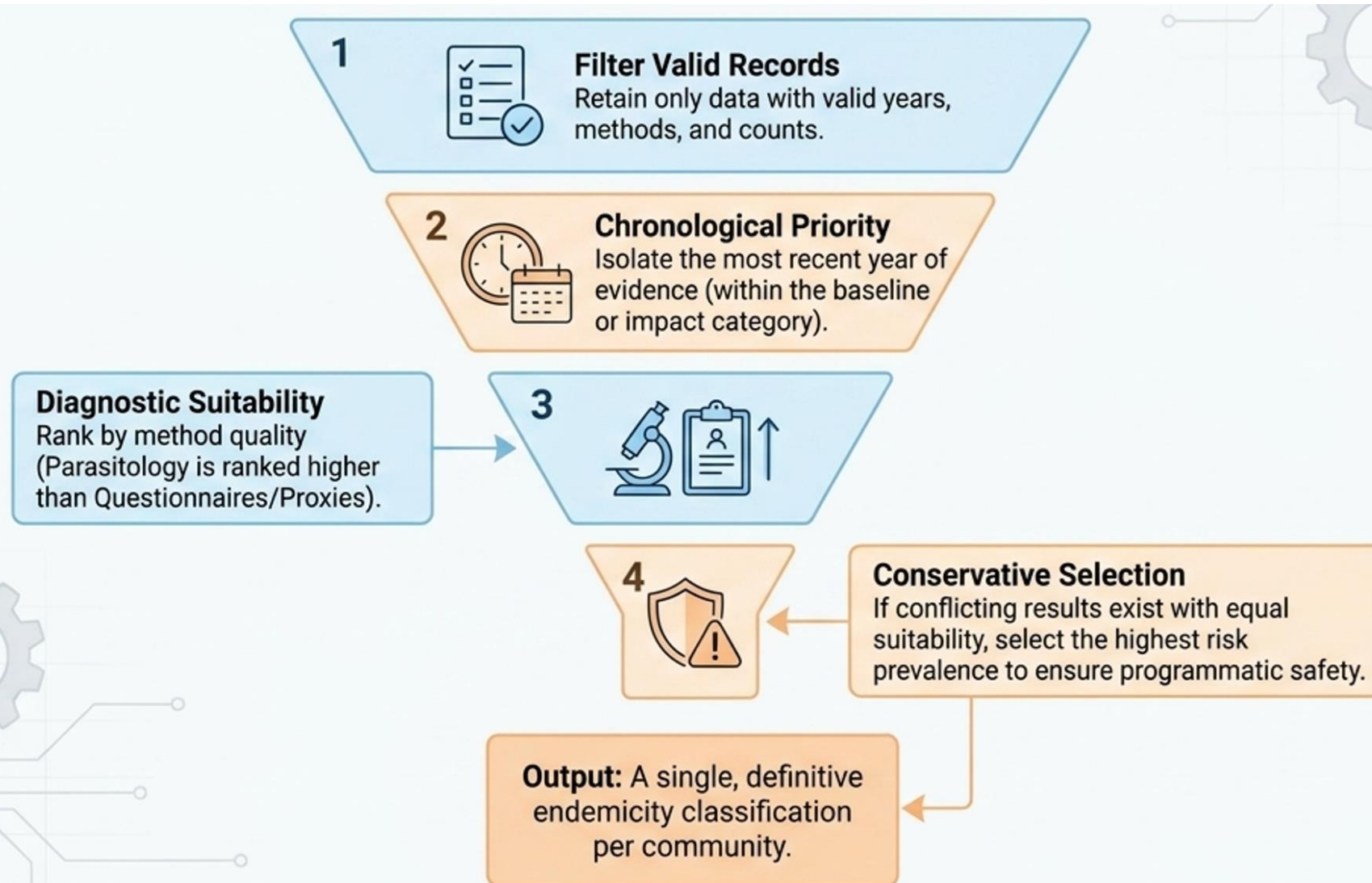
Avoid unweighted averages of site prevalence when aggregating

Document the source, method and quality for auditability

Calculation logic: Algorithm 1 – Survey classification



Calculation logic: Algorithm 2 – Select surveys informing prevalence



Calculation logic: Algorithm 3 – Endemicity into Treatment strategy

Version 6 aligns the treatment logic with the 2022 WHO schistosomiasis guideline.

Evidence category	Code examples	Planning interpretation
Baseline 0%	0	PC not required, unless new evidence indicates risk
Baseline <10%	1	Test-and-treat or low-frequency PC depending on country setting
Baseline 10–<50%	2	Annual PC recommended
Baseline ≥50%	3	Annual PC; consider enhanced action (biannual) if poor response
Impact <1%	99	Surveillance / test-and-treat depending on programme objective
Impact 1–<10%	11	Continue, reduce frequency or test-and-treat depending on PC history
Impact ≥10%	21 / 31	Annual PC or consider biannual PC if inadequate response

Important for data managers

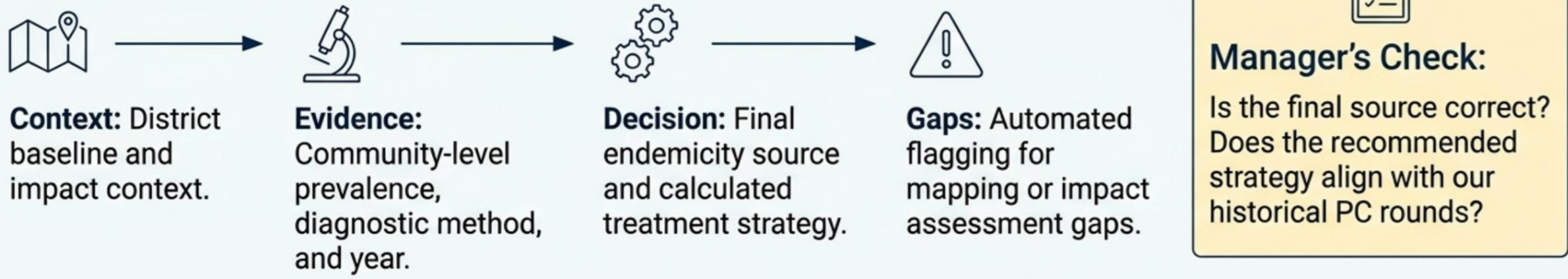
Treatment strategy depends on whether evidence is baseline or impact, PC history, and country parameters for low endemicity and reassessment intervals.

Outputs & planning: Output 1 – Community (*sub-IU*) Endemicity

Output Dashboard 1: Community Endemicity

District Context	Community Evidence	Final Endemicity Decision	Mapping/Impact Gaps
District A (Baseline & Impact Data)	Prevalence: 15%, Kato-Katz, 2023	Moderate Risk (Community Impact), Strategy: 1 round/year	Flag: None (Mapping Complete, Impact Assessment Due)

Read Left to Right to Validate:



Outputs & planning: Output 2 – IU Level estimates

Planning outputs convert treatment strategy into target populations and medicine quantities



PSAC

≥2 years, depending on formulation and programme guidance

SAC

school-age children

Adults

at-risk adults where strategy includes all age groups

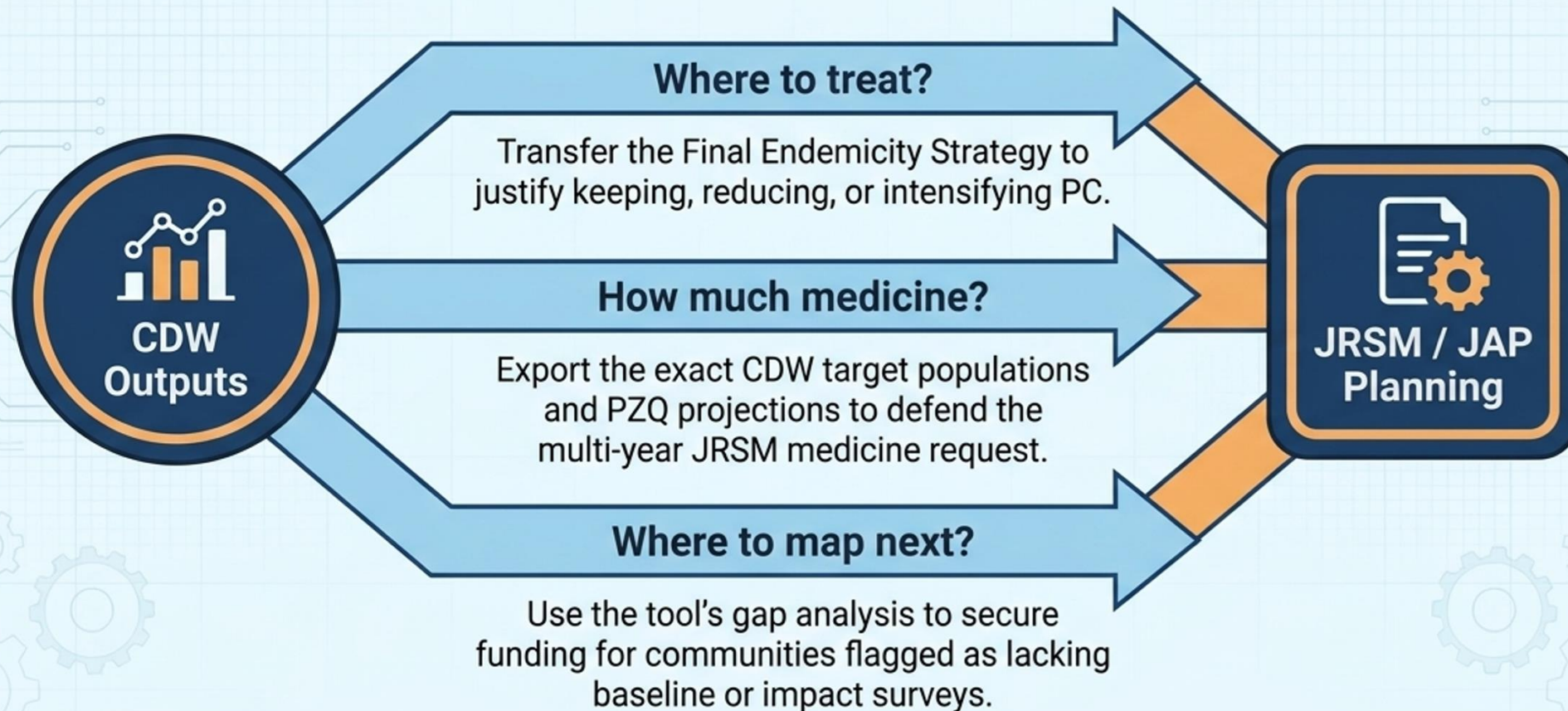
WRA

women of reproductive age where relevant to planning

The workbook supports scenario review: changes in population, coverage, treatment frequency or endemicity will change multi-year medicine requests

Outputs & planning: Output 3 – JRSM report (*export*)

Connecting the CDW to Multi-Year Planning (JRSM)



Country validation workflow

A practical sequence before using CDW outputs in planning.

- | | | | |
|----------|--|----------|---|
| 1 | Confirm structure
Sheet names, language, country settings, projection years | 4 | Check PC history
First/latest PC year, number of rounds, effective rounds |
| 2 | Check geographic links
IU ID, community ID, parent links, duplicate names | 5 | Check survey data
Survey type, year, method, examined/positive, coordinates, source quality |
| 3 | Check population
Year, age groups, growth, adjusted population, extreme values | 6 | Review outputs
Details → Summary → Projections → JRSM/PZQ request |

Recommendation: keep a change log of data updates, assumptions changed, and final country decisions.

Common data quality issues to catch early

Most output problems come from a small number of input inconsistencies.

- | | |
|--|---|
|  Broken links | Community record in epi_data does not match demo_data or IU_Data. |
|  Missing survey type | The algorithm cannot distinguish baseline from impact. |
|  Incomplete PC history | First/latest PC year or number of effective rounds missing or inconsistent. |
|  Small or missing denominators | Prevalence driven by very small samples or invalid examined/positive values. |
|  Method/species mismatch | Diagnostic method, species and disease type not aligned. |
|  Unreviewed parameters | Projection years or low-endemicity strategy not aligned with country decisions. |

A simple rule

When an output looks surprising, first check the input row and parameter sheet before changing the output manually.

SCH CDW v6.0: Expanding Coverage and Data Status



58,840

Broadened Footprint

The database now maps 38 countries, encompassing 4,422 IUs and an unprecedented 58,840 sub-IUs.

42.7%

Survey Data Growth

Of all sub-IUs are now actively informed by survey data, a sustained increase from July 2024.

68.9%

Baseline Predominance

Of informed sub-IUs continue to rely on historical baseline mapping data.

31.1%

Impact Integration

Are now informed by recent post-impact assessments, signaling active programmatic progression.

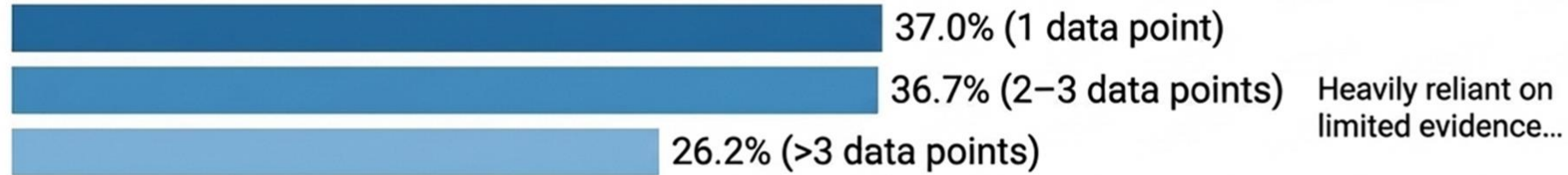


Geostatistical Modelling

Key nations (indicated by stars) are successfully leveraging spatial modelling to generate highly accurate sub-IU prevalence estimates.

SCH CDW v6.0: From Baseline Mapping to Impact Assessment

Baseline Mapping (18,945 sub-IUs)



Impact Assessment Data (8,417 sub-IUs)



Evidence Evolution

The transition from baseline mapping to impact assessments leads to stronger and more reliable data for decision-making.

Decision-Making Implications

Prioritizing multi-site impact reassessments is essential to confidently guide the scaling down of MDA.

THANK YOU

Questions & discussion

Dr Jorge Cano · Surveillance Officer, ESPEN — WHO Regional Office for Africa

Dr Pauline Mwinzi · Technical Officer, STH/SCH, ESPEN — WHO Regional Office for Africa

ESPEN NTD Portal · espen.afro.who.int

JRSM2027 STRUCTURE & ASSUMPTIONS

TRAINING WORKSHOP ON EFFECTIVE PC-NTDs DATA
PROCESSING AND USE FOR ENGLISH-SPEAKING COUNTRIES

*Kintélé International Conference Centre, Brazzaville (Congo)
24 to 28 August 2026*

Presenter: Dr Jorge Cano
ESPEN Surveillance Officer



World Health
Organization



HEALTH
FOR ALL

The Joint Application Package

How JAP Forms Drive NTD Planning:

● Epidemiological Foundation:

Field-level impact surveys (recorded on EPIRFs) define the actual endemicity and active transmission zones in implementation units.

● Accurate Drug Quantification:

The JRSM utilizes this survey-validated baseline to automatically compute precise medicine needs, ensuring zero over/under-procurement.

● Activities & Secured Funding:

The Annual Work Plan must detail implementation timelines and funding resources, as medicine donation is strictly subject to secured operational funds.

 **Joint request for selected PC medicines v.4.4**

As part of global efforts to accelerate expansion of preventive chemotherapy (PC) for control and elimination of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases, the World Health Organization (WHO) facilitates the supply of albendazole 400 mg tablets (GSK) to national lymphatic filariasis elimination programmes and national soil-transmitted helminth control programmes; diethylcarbamazine citrate 100 mg tablets (Eisai) to national lymphatic filariasis elimination programmes; mebendazole 500 mg tablets (J&J) for national soil-transmitted helminth control programmes; and praziquantel 600 mg tablets (Merck KGaA) for school-age children to national schistosomiasis control programmes. WHO also collaborates to supply ivermectin 3 mg tablets (Merck) for onchocerciasis and lymphatic filariasis donation programmes.

This Excel-based tool is designed to assist countries in quantifying the number of tablets of relevant PC medicines required to reach the planned target population and districts for the year of request. Output of the tool is a joint request for PC medicines which can be printed, signed and submitted to WHO to request these medicines.

Structure of the application (worksheets):

INTRO	This worksheet includes guides on how to complete the joint request for selected PC medicines and information about the status of PC for endemic diseases in the country.
COUNTRY_INFO	This worksheet includes information about administrative structure of the country, population by age group, status of endemicity for each disease, population requiring PC and planned interventions.
DEC, ALB, MBD, PZQ and IVM	These worksheets include information about endemic districts targeted for treatment with specified PC medicines, treatment plan, and number of tablets required and requested.
SUMMARY	This worksheet includes summary of number of tablets requested, information about stock, and date for submission of requested medicines. Before generating the report (run macros) please select the medicine for which the report is needed. Follow the same rule to see the number of people to be treated for the specific disease. This worksheet should be printed and submitted as a joint request for selected PC

 **PC Epidemiological Data Reporting Form v.4.2**

The purpose of this template PC Epidemiological Data Reporting Form (PC EPIRF) - available as an Excel file - is to provide national health authorities and data managers with a standardized tool to address these reporting challenges, facilitate integration and thereby further contribute to improving overall programme management. This template aims to standardize national reporting of epidemiological data on diseases targeted for preventive chemotherapy, improve availability and coordination of preventive chemotherapy data across the World Health Organization regions.

National authorities are requested to complete this form for submission to the World Health Organization on annual basis. This form could be submitted with the PC Joint Reporting Form (JRF).

Structure of the application (worksheets):

INTRO	This worksheet includes guides how to complete the PC epidemiological data reporting form and information about status of PC for endemic diseases in the country
LF	This worksheet includes indicators to report epidemiological data on lymphatic filariasis and section to report data on morbidity management and disability prevention
ONCHO	This worksheet includes indicators to report epidemiological data on onchocerciasis
STH	This worksheet includes indicators to report epidemiological data on soil-transmitted helminthiases
SCH	This worksheet includes indicators to report epidemiological data on schistosomiasis

 **PC Joint Reporting Form v.4.2**

The purpose of this template Joint Reporting Form (JRF) - available as an Excel file - is to provide national health authorities and data managers with a standardized tool to address these reporting challenges, facilitate integration and thereby further contribute to improving overall programme management. This template aims to standardize national reporting of programme implementation outcomes, improve availability and coordination of preventive chemotherapy data across the World Health Organization regions.

National authorities are requested to complete this form for submission to the World Health Organization within 3 months after the last round was implemented and no later than 31 March of the next implementation year

Structure of the application (worksheets):

INTRO	This worksheet includes guides on how to complete the joint reporting form and information about status of PC for endemic diseases in the country
COUNTRY_INFO	This worksheet includes information about administrative structure of the country, population by age group, status of endemicity for each disease, population requiring PC, planned interventions and interventions implemented
MDA1, MDA2, MDA3, MDA4, MDA5, T1, T2 and T3	These worksheets include information about endemic districts targeted for treatment with specified PC medicines, treatment plan, and number of people who received treatment by age group. Depending on co-endemicity of the diseases in a country the tool will generate respective worksheets to fill in
DISTRICT	This worksheet includes summary of people treated by disease at the level of implementation. If data by gender is available, it requires to enter.
SUMMARY	This worksheet includes summary of people treated by disease and by PC intervention. Before generating the report (run macros) please select the disease for which you need the report. Follow the same rule to generate various reports. This worksheet should be printed and submitted as a Joint Report (see the instruction for submission in the SUMMARY worksheet).

 **Annual Work Plan**

As part of the global efforts to accelerate expansion of preventive chemotherapy (PC) for elimination and control of lymphatic filariasis, schistosomiasis, soil-transmitted helminthiases and onchocerciasis, the World Health Organization (WHO) facilitates the supply of necessary medicines. In order to request for medicines, submission of the Annual Work Plan together with the Joint Request for selected PC medicines and the Joint Reporting Form is a requisite.

Annual Work Plan allows the national programmes to identify the specific objectives to be achieved in the year, to focus on the key activities that needs to be implemented to achieve the said objectives, and to identify the gap in financial and technical resources to achieve the objectives. It also allows WHO to closely monitor the progress of the national programmes, and to identify the obstacles and coordinate for provision of financial and technical support in time.

Information to be included in the Annual Work Plan

- ☐ Name of country
- ☐ Implementation year
- ☐ Relevant preventive chemotherapy diseases
- ☐ Specific programme targets to achieve in the year
- ☐ Annual work plan matrix comprising a list of activities and sub-activities with:
 - Timeline of implementation
 - Estimated cost
 - Available or committed funds
 - Funding gap
 - Funders

Deadlines secure timely drug procurement and reporting

Medicine Request: JRSM

SUBMISSION DEADLINE:
At least 9 months before planned MDA

Example scenario:

- First planned MDA: May 2026
- Required JRSM Submission: August 2025 at the latest

Why? Allows a minimum of 9 months for international shipping, customs clearance, and national-to-district distribution logistics.

Reporting: JRF & EPIRF

JRF DEADLINE: Within 3 months after MDA

EPIRF DEADLINE: Immediately post-survey

Reporting examples:

- MDA completes April 2024 -> JRF submitted by July 2024
- Survey completes May 2025 -> EPIRF submitted by June 2025

Why? Rapid reporting enables immediate technical reviews and feeds up-to-date data directly into the next drug planning cycle.

Five key worksheets form the core JRSM excel architecture

Worksheet Roles & Navigation:

- **INTRO Tab:**

Enter country metadata, identify endemic diseases, and provide age-group percentage splits.

- **COUNTRY_INFO Tab:**

List all implementation units (IUs) alongside corresponding target populations, endemicities, and treatment rounds.

- **ALB_MBD / PZQ / IVM Tabs:**

Worksheets generated dynamically based on INTRO selections. Computes raw requirements and adjusts for current national inventory.

- **SUMMARY Tab:**

Automated rollup sheet detailing tablet needs per medicine, shipping targets, and funding sources.

- **SHIPMENT Tab:**

Input consignee, warehouse destination, delivery timelines, and special packaging requirements.



Joint request for selected PC medicines v.4.4

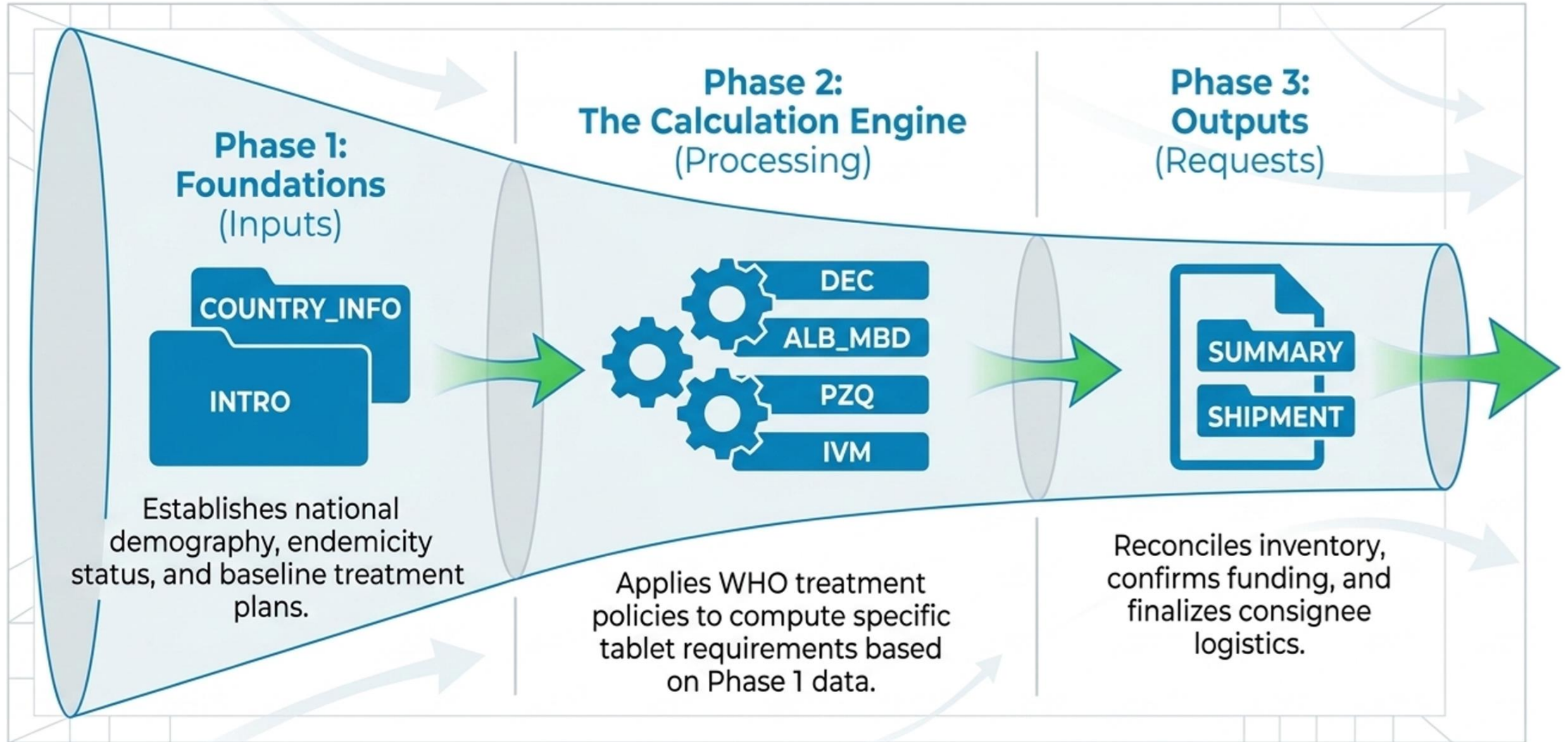
As part of global efforts to accelerate expansion of preventive chemotherapy (PC) for control and elimination of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases, the World Health Organization (WHO) facilitates the supply of **albendazole** 400 mg tablets (GSK) to national lymphatic filariasis elimination programmes and national soil-transmitted helminth control programmes; **diethylcarbamazine citrate** 100 mg tablets (Eisai) to national lymphatic filariasis elimination programmes; **mebendazole** 500 mg tablets (J&J) for national soil-transmitted helminth control programmes; and **praziquantel** 600 mg tablets (Merck KGaA) for school-age children to national schistosomiasis control programmes. WHO also collaborates to supply **ivermectin** 3 mg tablets (Merck) for onchocerciasis and lymphatic filariasis donation programmes.

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Core Architecture of the JRSM: Sequential Pipeline



Step 1: The INTRO Tab established the baseline parameters

Country data

COUNTRY	Motanga
Year for request of the medicine	2025
Is country endemic for lymphatic filariasis (LF) ?	Endemic
Is country endemic for onchocerciasis (ONCHO) ?	Endemic
Is country endemic for soil-transmitted helminthiases (STH) ?	Endemic
Is country endemic for schistosomiasis (SCH) ?	Endemic
How many administrative units in the country?	20

If demographical data at the second administrative level are not available by age group, please enter the proportion (%) of population by age group in the country. If data are available, please leave these cells blank.

1-4 years age	Preschool-age children (PreSAC)	10.65%
5-14 years age	School-age children (SAC)	24.71%
15 years +	Adults	61.23%
15-49 years	Women of reproductive age (WRA)	24.77%

Restore full version Clear form Generate new form

1 Toggle endemicity status for LF, ONCHO, STH, and SCH.

2 Define demographic proportions (PreSAC, SAC, Adults, WRA) if secondary administrative level data is unavailable.

Step 2: The COUNTRY_INFO Tab maps interventions at IU level

1 Implementation Units (IUs) & Demography: Total populations broken down by administrative structure.

2 Endemicity Status: Mapped per disease at the IU level.

3 Population Requiring PC: Adjusted to the transmission zone, directly influencing the calculation engine.

TOTAL			7,661,600	815,216	1,893,514	4,091,000						3,695,640	3,185,241	256,175	591,641	991,466	1,254	435,266	1,246,980	1,341,733	5,158,697								
Country administrative structure			Population				Exdemicity					Population requiring PC										Number of treannrounds planned for this year				Epidemiological surveys planned for the year			
Country	Province/State	District	Total	PreSAC	SAC	Adults	LF	Dncha	STH	SCH	Loa	LF	ONCHO	STH				SES				LF	Oncho	STH	SCH	LF	Onche	STH	SCH
														PreEAC	SAC	WRA	TOTAL	PreSAC	SK6	Adults	TOTAL								
Botswana	SEBEL	Redding	275,545	20,532	64,600	108,799	5	0	1	0		Stepped	Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Botswana	SEBEL	Verebebe	165,251	89,295	143,100	192,155	93	4	1	1			Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Botswana	SEBEL	Aenpriet	195,356	15,305	55,900	55,790	4	0	1	1			Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Botswana	SEBEL	Petlemerah	257,879	29,750	82,560	132,159	1	5	1	3		231,070	251,070	0	0	0	0	30,500	32,500	153,166	232,567	1	1	0	1				
Botswana	SEBEL	Peetmouat	141,012	26,295	82,530	152,156	1	1	1	2		162,423	203,004	0	0	0	0	19,430	41,500	193,148	372,360	1	1	0	1				
Botswana	SEBEL	Mapotriel	168,650	17,936	41,800	163,145	1	1	1	2		166,442	186,663	0	0	0	0	12,900	41,660	102,146	199,256	1	1	0	1				
Botswana	SEBEL	Amogoni	143,077	16,207	42,759	127,619	0	0	1	5		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Botswana	SEBEL	Ryryatse	63,656	8,599	88,373	45,649	0	0	1	1		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Botswana	SEBEL	Stas	165,930	16,160	16,519	112,255	0	0	1	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Botswana	SEBEL	Gurufeark	55,512	56,843	271,663	515,552	5	0	1	2		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Botswana	SEBEL	Qelilots	345,150	96,161	265,130	515,728	0	0	1	2		0	0	0	0	0	0	67,500	208,116	916,126	231,835	0	0	0	1				
Botswana	SEBEL	Tnereveta	853,321	22,055	38,323	131,637	1	1	1	2		334,327	233,022	0	0	0	0	58,275	33,699	130,652	253,225	1	1	0	1				
Botswana	SEBEL	Melcolong	336,133	23,160	59,532	595,470	0	0	1	3		Stepped	Unknown	0	0	0	0	39,293	52,500	194,395	319,276	3	1	0	1				
Botswana	SEBEL	Pharopio	552,153	36,767	85,700	852,467	1	1	2	3			351,640	283,965	35,702	65,794	90,010	215,811	56,100	55,799	555,163	541,116	1	1	1	1			
Botswana	SEBEL	facilian	364,959	36,109	59,162	838,930	1	1	3	2		361,650	309,200	36,102	95,726	80,315	265,344	30,330	34,336	236,063	307,316	1	1	1	1				
Botswana	SEBEL	Carnalen	311,550	82,185	151,127	376,048	1	1	2	2		511,622	611,696	34,196	121,710	127,212	257,815	28,206	121,161	513,266	376,616	1	1	1	1				
Botswana	SEBEL	Ardies	495,119	29,077	54,723	173,629	39	1	2	3		Stepped	Unknown	0	0	0	0	95,927	96,239	771,979	22,329	99,503	100,822	257,929	0	1	1	1	
Botswana	SEBEL	Rortiberg	396,133	32,090	88,262	290,150	15	1	2	3			290,111	666,278	37,580	99,533	55,230	313,923	27,250	99,600	295,797	523,096	0	1	1	1	1	1	
Botswana	SEBEL	Lufitso	400,153	43,210	107,050	595,659	12	1	2	1		336,110	650,323	46,176	107,950	107,950	293,633	0	0	0	0	0	0	1	1	0	766		
Botswana	SEBEL	Friste	436,737	33,875	217,177	295,757	12	1	1	3		852,150	876,757	0	0	0	0	0	0	70,217	211,112	235,199	823,665	0	1	0	0		
Botswana	SEBEL	Repucci	341,950	23,300	88,462	235,269	0	4	1	1		Unknown	Unknown	0	0	0	0	0	0	6	6	6	6	5	5	0	0		
Botswana	SEBEL	Nesell	341,835	31,805	83,419	209,265	0	2	1	1		Unknown	Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

Remember: Track variations in IU divisions carefully to prevent unjustified variations in demographics.

Step 3: The Calculation Engine automates WHO Treatment Policy

The Legend

White/Orange: Open for data entry / drop-downs.

Yellow/Blue: Protected cells (No data entry required).

Green: Contains formula (Change ONLY if varying from automatic WHO calculation).

<

The tool **automatically computes tablet requirements** based on **INTRO** and **COUNTRY_INFO** data. Simply select the specific medicine (e.g., ALB or MBD) for each target age group.

Step 3b: PZQ calculation & Hotspot Targeting

Praziquantel (PZQ)
Administrative structure, eligible population by age group, treatment plan and information about tablets

TOTAL		436,029	1,348,398	3,341,259	1,139,487		
Country	Province/State/District	Treatment plan SCH	PresAC	SAC	Adults	Planned	Population
Motanga	SYBIL Barking	0	0	0	0	0	0
Motanga	SYDIL Vonifees	0	0	0	0	0	0
Motanga	SYDIL Ashpoint	0	0	0	0	0	0
Motanga	SYBIL Portsmarch	1	20,060	62,048	153,355	235,647	
Motanga	SYBIL Westhall	1	13,425	41,628	103,148	189,230	
Motanga	SYBIL Anngaal	0	0	0	0	0	0
Motanga	SYBIL Kyside	0	0	0	0	0	0
Motanga	SYBIL Nex	0	0	0	0	0	0
Motanga	SYDIL Soatfiwerk	1	69,805	212,440	156,677	811,308	
Motanga	SYDIL Quintus	1	67,600	209,115	176,155	704,895	
Motanga	ZOMEA Tuskenvale	1	16,273	59,037	143,821	220,678	
Motanga	ZOMEA Malunbag	1	20,321	62,560	153,975	592,316	
Motanga	ZOMEA Princeton	1	29,533	99,798	224,487	506,161	
Motanga	ZOMEA Huwen	1	25,553	89,782	224,965	566,166	
Motanga	ZOMEA Camden	1	48,866	151,141	374,505	336,666	
Motanga	ZOMEA Aralas	1	21,966	66,523	168,856	225,262	
Motanga	ZOMEA Grafburg	1	27,875	66,830	211,175	323,680	
Motanga	ZOMEA Lulhpla	1	0	0	0	0	0
Motanga	ZOMEA Findie	1	78,211	217,173	538,101	825,485	
Motanga	ZOMEA Roscaff	0	0	0	0	0	0

1 The **SCH Requirement**: PZQ calculations rely heavily on targeted school-age children (SAC) and adult populations.

2 **Hotspot Integration**: If recent impact assessment results reveal ongoing transmission zones, data managers must enter the number of rounds and target populations **specifically in the highlighted Hot spots columns**.

3 **Previous MDA Data**: Tracking prior rounds ensures continuity and justifies ongoing tablet requests.

Step 4: Finalizing Outputs in the SUMMARY & SHIPMENT Tabs

Verify Funding: Confirm availability of funds for implementation in the requested year (donations require secured operational funding).

Checklist

What should be submitted?
The supply of the requested medicines should be based on up-to-date epidemiological data, specific usage plans, and capacity for implementation. The following checklist ensures that all necessary forms and information are provided to WHO (in electronic format)

- ☐ Joint request for selected PC medicines
- ☐ Joint reporting form
- ☐ PC epidemiological data reporting form

Availability of funding for implementation in the year for which the medicines are requested

Diseases targeted for implementation	Total treatments	Funding secured for	Source	Amount
Lymphatic filariasis	1,18,152			
Onchocerciasis	3,555,376			
Schistosomiasis				
Self-transmitted h				

Define Logistics: Establish precise dates for when medicines must arrive at the national warehouse (linking back to the 9-month planning cycle).

Consignee Details: Accurate shipment info prevents customs delays.

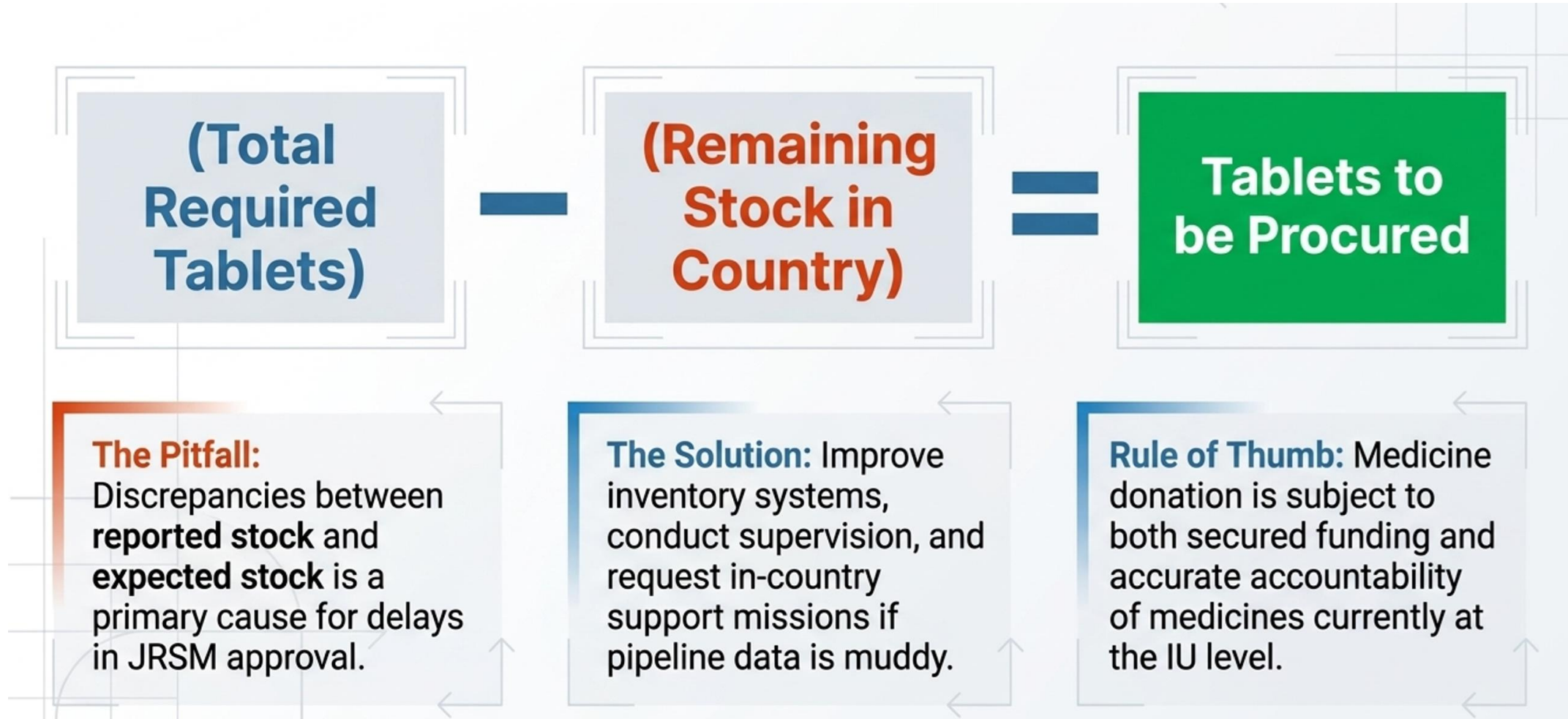
Information on shipment and consignee

	Consignee	Delivery point / Final recipient if different from the consignee
Name		
Department/Unit		
Organization		
Phone		
Fax		
E-mail		
Mailing address		

Final Step: Print, sign, and submit the generated PDF to the WHO WR.

SUMMARY worksheet

*The **Reconciliation variable**: accurate inventory prevents delays*



COMMON PITFALLS IN THE JRSM PROCESS



Data Processing

Pitfall: Limited use of modern tools leading to poor quality submissions.

Solution: Capacity building, peer learning, AI tools.



Epidemiology

Pitfall: Late availability of impact assessment results.

Solution: Timely EPIRF submissions to inform SCW and JRSM.



Inventory

Pitfall: Unexplained variations in leftover stock at the IU level.

Solution: Better accountability and IU-level tracking.



Strategy

Pitfall: Unjustified variations in demographics or PC strategy from year to year.

Solution: Stick to validated projections and WHO guidelines.

ESPEN SUPPORT: PREPOPULATION JRSM

ESPEN provides pre-populated JAP forms to dramatically reduce country workload.

95%

95% of JRSM Content Filled

Includes forecasting tables and demographic projections.

Official Census Integration

Uses 2025-2030 official data mapped accurately to up-to-date IU levels.

Institutional Memory

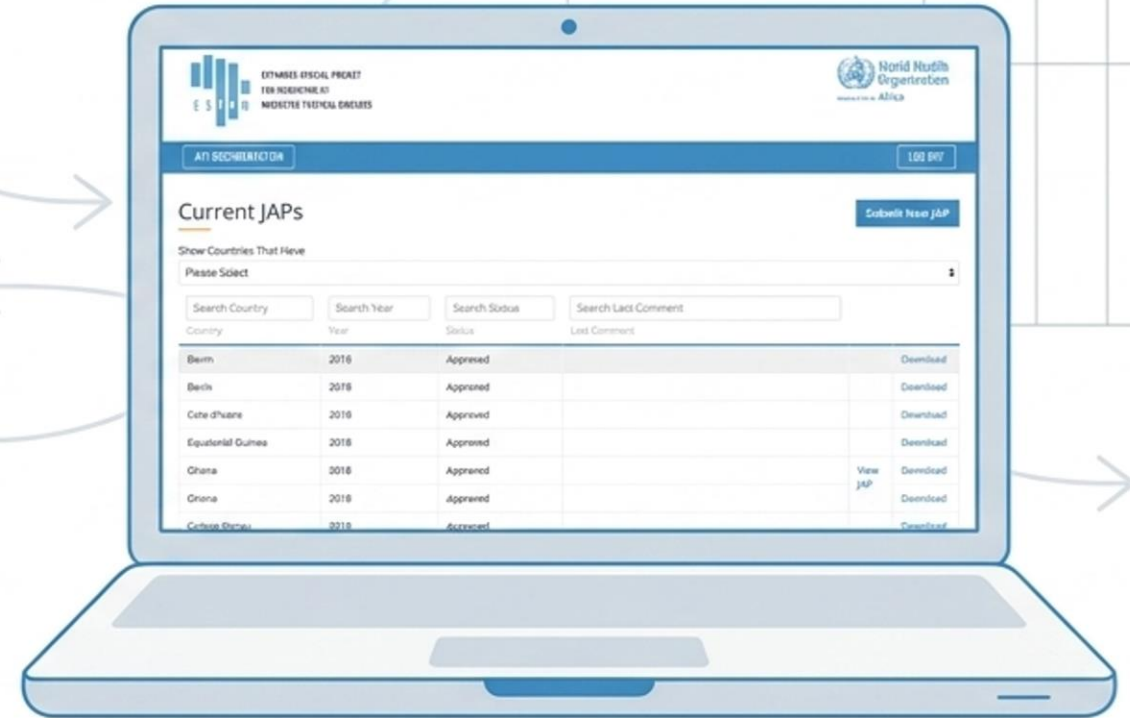
Mitigates the impact of NTD program staff turnover.

Quality Control

Prevents unjustified variations in demographics, endemicity, or strategy.

Final Checklist & The JAP Upload Tool

- ✓ Have you used validated demographic projections?
- ✓ Are Schisto hotspots and SCW data accurately reflected?
- ✓ Is your inventory reconciled (Required - Stock = Requested)?
- ✓ Is implementation funding secured and documented?



Submit via the online JAP Upload Tool to ensure visibility, track review status, and prevent files from getting lost in recipient inboxes.

THANK YOU

Questions & discussion

Dr Jorge Cano · Surveillance Officer, ESPEN — WHO Regional Office for Africa

ESPEN NTD Portal · espen.afro.who.int

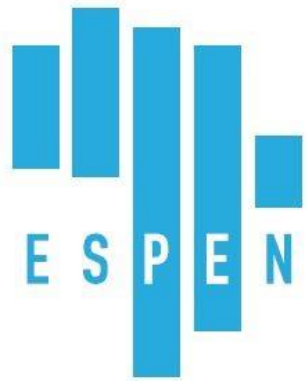


**TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING**
NTD Data Use, Reporting and Supply Chain
Capacity

Kintélé, Brazzaville,
Republic of the Congo

**Advances in Data and Analytics for
Sustaining NTD Elimination in
Africa - JAP Process Assistant**





EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

Advances in Data and Analytics for Sustaining NTD Elimination in Africa - ESPEN JAP Process Assistant

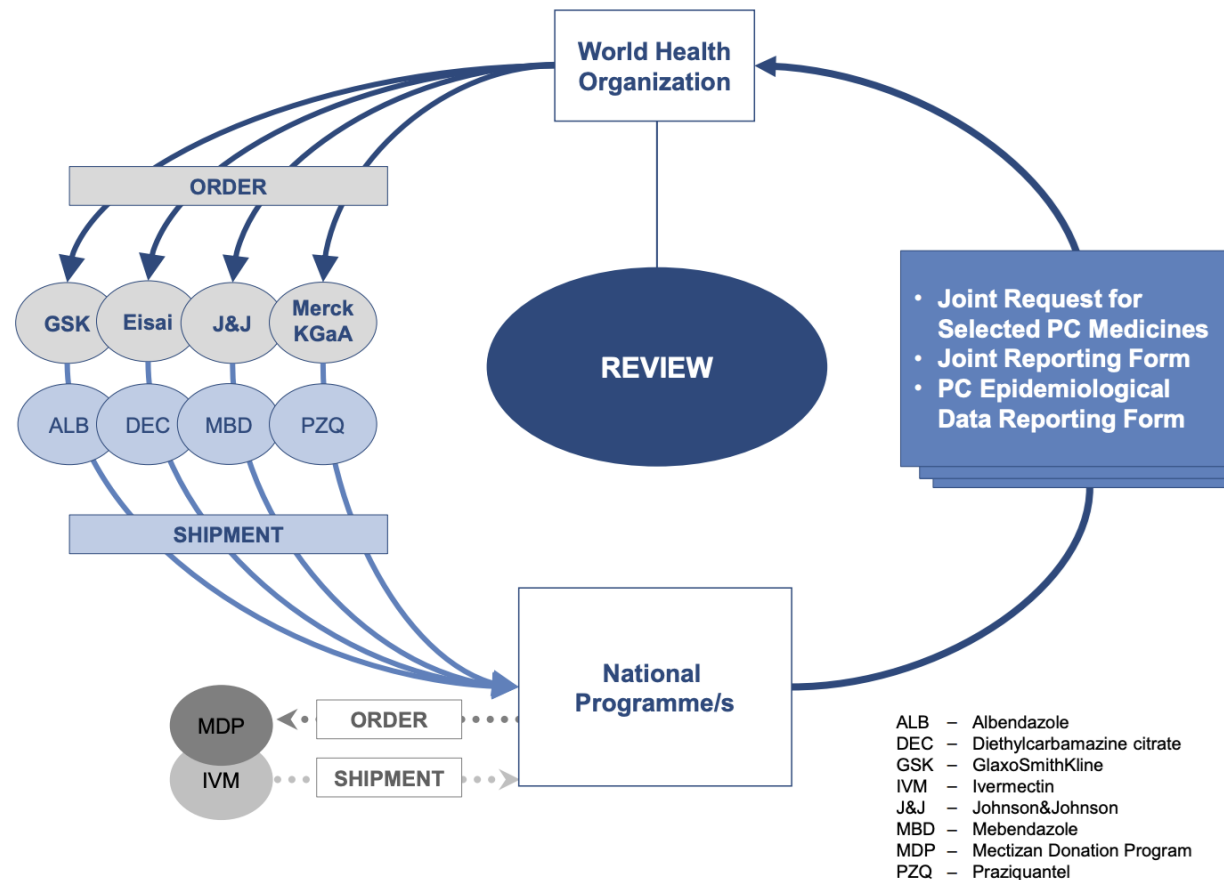
In collaboration with **dimagi**

Agenda

1. Background
 - a. What is JAP?
 - b. Background
 - c. Current State: Manual JAP Review Process
2. JAP Process Assistant Overview
3. Development and Release Phases
4. Step-by-Step Walkthrough
5. Next Steps

The JAP is how countries request donated medicines, and report treatment coverage — the PC-NTD data backbone

The Joint Application Package (JAP) Process



Background

Challenge in JAP Data Review

- Evaluating JAP submissions is traditionally a manual, time intensive process for both ESPEN and national teams.
- Reviewers frequently face challenges with formula integrity, version mismatches, and aligning data against historical database baselines.
- When a JAP is submitted with data quality issues, it delays approval process and the arrival of medicines for MDA

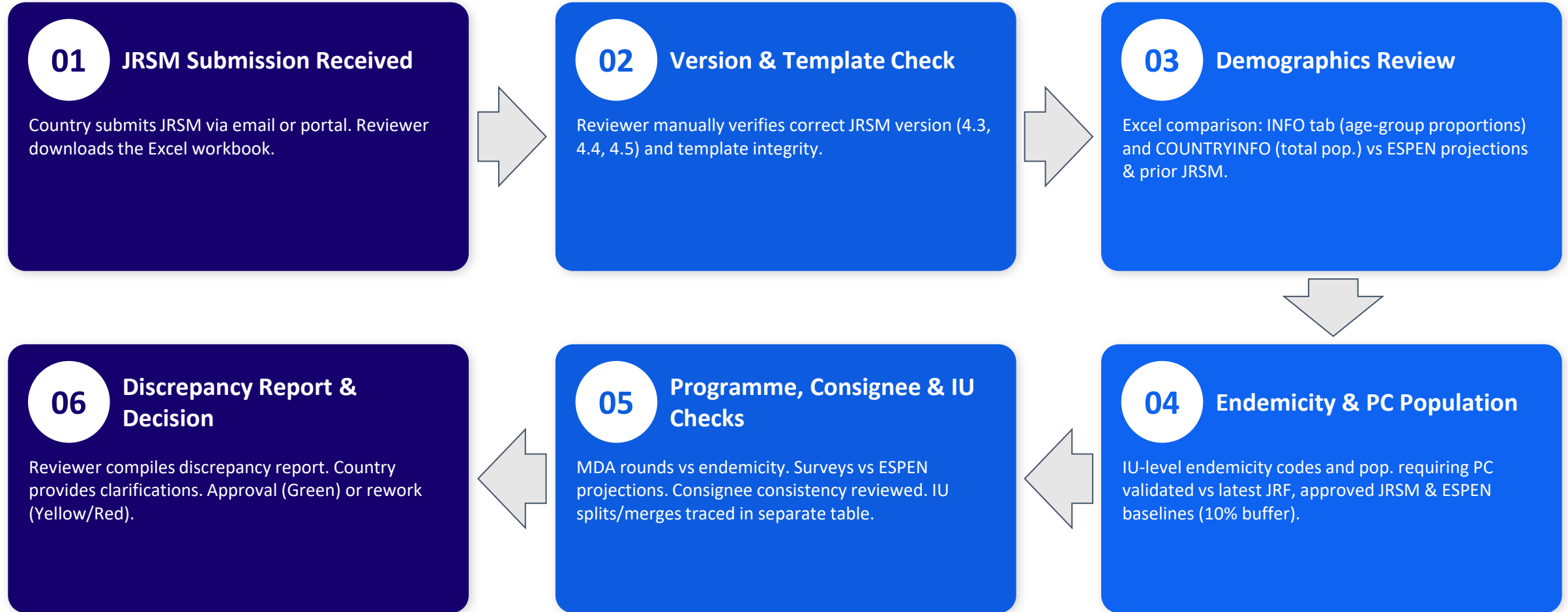
Need for JAP Automation

- A critical bottleneck exists in the feedback loop between country submissions and final approvals.
- Streamlining this process is vital to accelerate data-driven treatment decisions for sustaining NTD elimination across Africa.
- Ensure sufficient quantities of donated medicines are shipped on time for MDA implementation

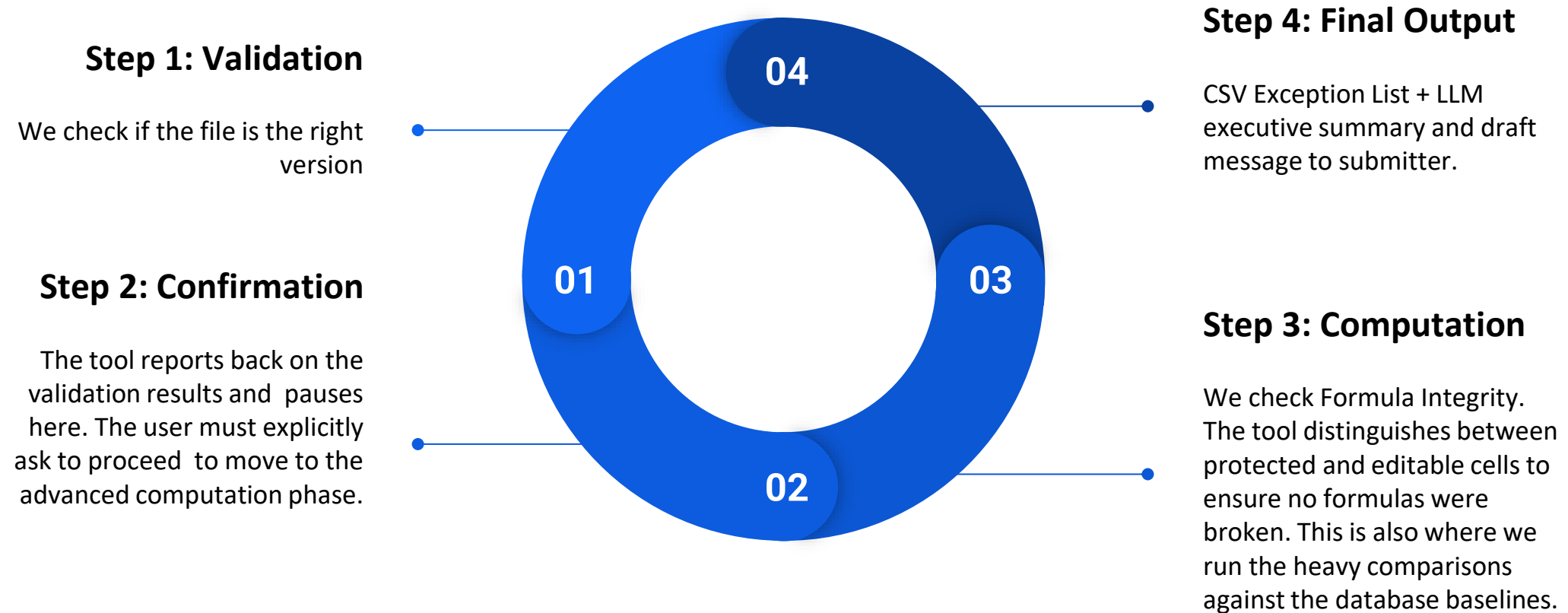
Our Objective

- Introduce an AI-powered JAP Process Assistant to automate validation, flag discrepancies instantly, and provide a collaborative tool for both ESPEN and country teams to radically simplify the feedback loop.

Current State: Manual JAP Review Process



Future State: JAP Process AI Assistant

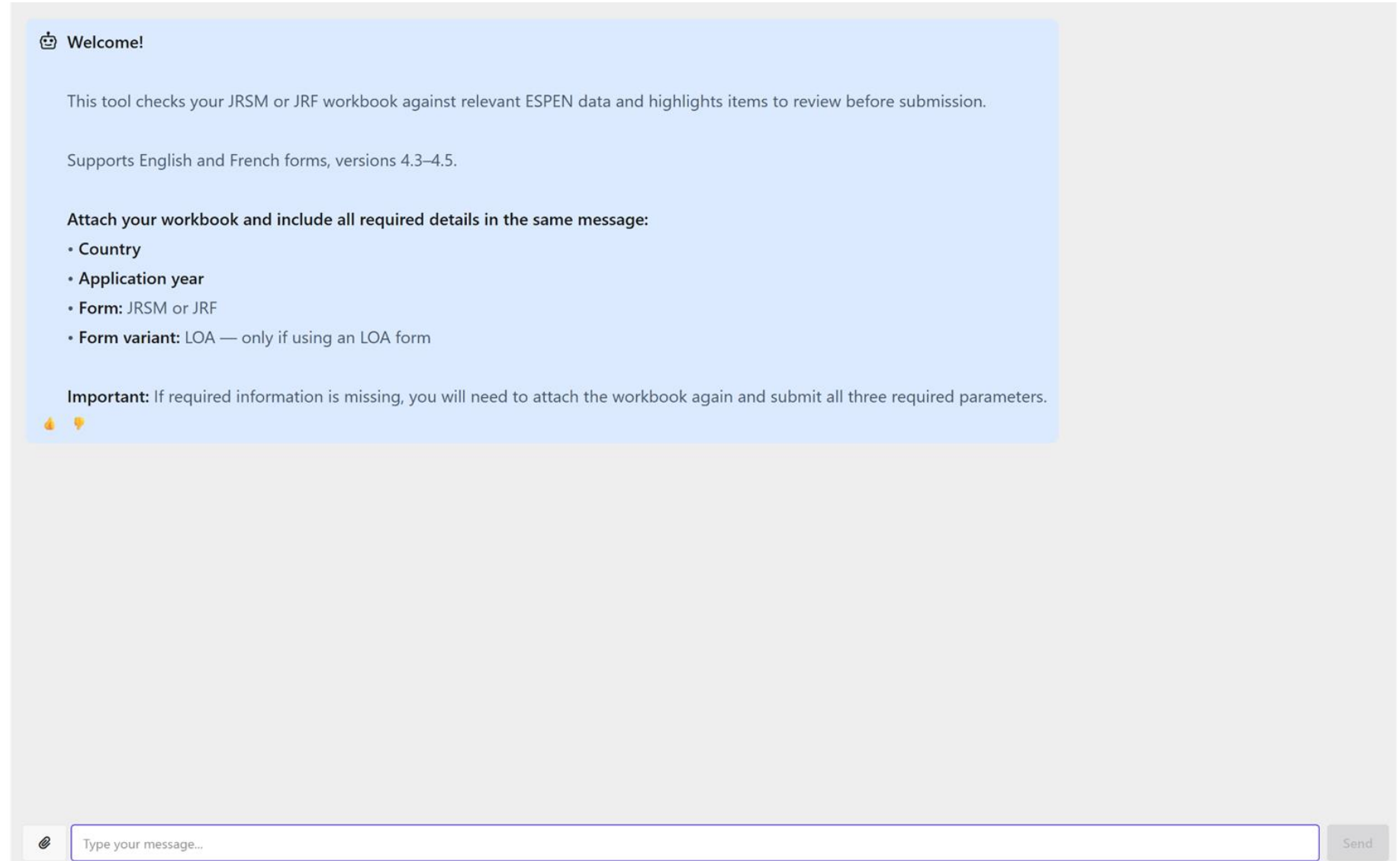


Step-by-Step Walkthrough: Step 1

Access the AI Tool

Access the tool by clicking on the following link:

<https://www.openchatstudio.com/a/ai-assistant-for-ntds/chatbots/861fcbfa-fe73-416a-8ca3-e1a0194bb050/start/>



 Welcome!

This tool checks your JRSM or JRF workbook against relevant ESPEN data and highlights items to review before submission.

Supports English and French forms, versions 4.3–4.5.

Attach your workbook and include all required details in the same message:

- Country
- Application year
- Form: JRSM or JRF
- Form variant: LOA — only if using an LOA form

Important: If required information is missing, you will need to attach the workbook again and submit all three required parameters.

 Type your message...

Send

Step-by-Step Walkthrough: Step 2

Specify country, year and form

Mention the country, year of application and form type (JRSM) along with upload of the relevant JRSM form in the input field.

Supported JRSM versions: 4.3, 4.4 & 4.5

Welcome!

This tool checks your JRSM or JRF workbook against relevant ESPEN data and highlights items to review before submission.

Supports English and French forms, versions 4.3–4.5.

Attach your workbook and include all required details in the same message:

- Country
- Application year
- Form: JRSM or JRF
- Form variant: LOA — only if using an LOA form

Important: If required information is missing, you will need to attach the workbook again and submit all three required parameters.

Upload here Type here

jrsm, ghana, 2026

Send

Uploaded Files

1 Ghana_JRSM2026_v41final_V1_2026_2701_%281%29_2026_02202026_1771602975.xlsm

Step-by-Step Walkthrough: Step 2

Select JRSM to test

You can use a previously submitted JRSM form to test by clicking on this link (filter for 2026): <https://espen.afro.who.int/tools-resources/data-reporting-tools/jap-search>

Country:

All

Year:

2026

Type:

JRSM

Status:

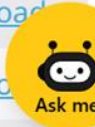
Approved

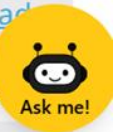
Showing 1 to 25 of 38 entries (filtered from 1,061 total entries)

Show

25

Country	Year	Type	Status	Updated	Download
Benin	2026	JRSM	Approved	23 May 2025	Download
Botswana	2026	JRSM	Approved	27 Jun 2025	Download
Burkina Faso	2026	JRSM	Approved	14 Oct 2025	Download
Burundi	2026	JRSM	Approved	26 Nov 2025	Download
Cameroon	2026	JRSM	Approved	15 Oct 2025	Download
Central African Republic	2026	JRSM	Approved	10 Sep 2025	Download

 Ask me



Step-by-Step Walkthrough: Step 3

Review AI summary

The tool generates an AI summary by validating the uploaded JRSM form.

Type 'yes' to proceed with the computation phase.

jasm, ghana, 2026

Ghana_JRSM2026_v41final_V1_2026_2701_%281%29_2026_02202026_1771602975.xlsm

Executive Summary

- Formula-governed cells appear to have been overwritten or cleared in COUNTRY_INFO and PZQ, which may affect downstream calculations.
- Several medicine module stock fields are blank across active implementation-unit rows; confirm whether these medicine lines are active and require stock reporting.
- SUMMARY contact/authorization fields have possible missing entries that should be checked before submission.

Priority Findings

- COUNTRY_INFO column M contains many literal values where formulas are expected; review whether these overrides were intentional.
- PZQ column E appears blank where formulas are expected across active rows; this may indicate formula removal.
- Possible review item: ALB_MBD, PZQ, and IVM remaining-stock fields are blank across many active rows; verify applicability for active medicine requests before completion.
- SUMMARY contact metadata and authorization fields have missing or invalid entries, including rows around 72 and 84–85.

Suggested Review Areas

- Restore workbook formulas in governed cells where changes were not intentional.
- Confirm stock reporting requirements for active ALB, PZQ, and IVM request lines.
- Review visible SUMMARY contact and authorization sections for completeness.

Next step:

Would you like me to compare this submission to baseline data?

yes

Send

Step-by-Step Walkthrough: Step 4

Download file

The tool runs the final step with the following outputs:

1. An executive summary
2. A downloadable file with the computation outcome

Compute completed for 261 active IU rows with 14 grouped warning findings. All active rows were matched to baseline IUs, and a review workbook was generated:

`jap_compute_review.xlsx`

Top items to review

1. **ONCHO population requiring PC changed broadly** — 121 rows show >10% differences, plus additional rows with zero-baseline or blank-value comparison limits. This matters because ONCHO PC populations directly affect treatment planning and medicine requirements. Review COUNTRY_INFO column M in the review workbook, starting with examples such as Asutifi North and Asutifi South.
2. **Total population differs from baseline** — 90 rows differ from the 2025 comparison baseline by more than 5%. This matters because total population is the basis for multiple downstream target-population calculations. Review COUNTRY_INFO column D in the review workbook, starting with examples such as Asunafo North and Asunafo South.
3. **SCH population requiring PC changed consistently** — 31 rows show >10% differences across SCH PreSAC, SAC, Adults, and Total fields. This matters because the same IU pattern appears across multiple SCH target groups, suggesting a broad input or calculation change. Review COUNTRY_INFO columns R–U in the review workbook, starting with Atwima Nwabiagya and Abuakwa North.
4. **Endemicity status changes** — LF endemicity changed for 5 rows and Oncho endemicity changed for 11 rows. This matters because status changes can change whether PC is expected, stopped, or outside scope. Review COUNTRY_INFO columns H and I in the review workbook, starting with Sunyani West for LF and Afigya Kwabre South for Oncho.
5. **STH PC populations added where baseline was zero** — 9 rows have STH PreSAC, SAC, WRA, and Total values where the comparison baseline was zero. This matters because these may represent new STH PC requirements or data-entry/coding changes needing confirmation. Review COUNTRY_INFO columns N–Q in the review workbook, starting with Afigya Kwabre South and Bekwai Municipal.

Suggested review order

1. COUNTRY_INFO Oncho PC population, 2. endemicity changes, 3. total population differences, 4. SCH PC population differences, 5. STH zero-baseline PC population entries.

 `jap_compute_review.xlsx`

Download this

Type your message... Send

Step-by-Step Walkthrough: Step 5

Open the workbook

Open the file generated by the tool. You will notice similarities with the original submission along with some new columns and sheets.

The screenshot shows the Microsoft Excel interface with the following elements:

- File Name:** jap_compute_review_SAct... • Saved to this PC
- Ribbon:** Home (selected), Insert, Draw, Page Layout, Formulas, Data, Review, View, Automate, Help.
- Font Group:** Calibri, 11, Bold (B), Italic (I), Underline (U), Color (A), Background Color.
- Alignment Group:** Left, Center, Right, Indent, Decrease Indent, Increase Indent, Wrap Text, Merge & Center.
- Number Group:** General, Percentage (%), Decimal, Fraction, Date & Time, Text, Currency, Accounting, More Numbering.
- Styles Group:** Conditional Formatting, Format as Table, Cell Styles.
- Cells Group:** Insert, Delete, Format.
- Formulas Bar:** A1, fx.
- Worksheet Title Bar:** Joint request for selected PC medicines v.4.4
- Worksheet Content:**
 - Paragraph 1:** As part of global efforts to accelerate expansion of preventive chemotherapy (PC) for control and elimination of lymphatic filariasis, transmitted helminthiasis, the World Health Organization (WHO) facilitates the supply of albendazole 400 mg tablets (GSK) to national lymphatic filariasis programmes and national soil-transmitted helminth control programmes; diethylcarbamazine citrate 100 mg tablets (Eisai) to national lymphatic filariasis programmes; mebendazole 500 mg tablets (J&J) for national soil-transmitted helminth control programmes; and praziquantel 600 mg tablets (Merck) to national schistosomiasis control programmes. WHO also collaborates to supply ivermectin 3 mg tablets (Merck) to national lymphatic filariasis donation programmes.
 - Paragraph 2:** This Excel-based tool is designed to assist countries in quantifying the number of tablets of relevant PC medicines required to reach the plan districts for the year of request. Output of the tool is a joint request for PC medicines, which can be printed, signed and submitted to the relevant authorities.
- Table of Contents:**

Structure of the application (worksheets):	
INTRO	This worksheet includes guides on how to complete the joint request for PC medicines and information about the status of PC for endemic countries.
COUNTRY_INFO	This worksheet includes information about administrative structure, population by age group, status of endemicity for each disease and planned interventions.
- Worksheet Tabs:** INTRO (selected), COUNTRY_INFO, ALB_MBD, IU_MATCH, DEMOGRAPHICS, ENDEMICITY.

Step-by-Step Walkthrough: Step 5

Review the workbook

Reading the file:

Observe the Population section on the COUNTRY_INFO tab. Herein, you will notice the total as entered alongside a comparison with the baseline as well as the % difference. Similar fields exist for Endemicity and Population requiring PC. These are further shown separately in individual sheets on the same file.

The screenshot shows the Microsoft Excel interface with the 'COUNTRY_INFO' tab selected. The table data is as follows:

Administration			Population		
Country	Province/State	District	Total population (current)	Total population (baseline 2025)	Total population (delta %)
Ghana	Ahafo	Asunafo North	169,490	161,395	5.0%
Ghana	Ahafo	Asunafo South	102,746	97,838	5.0%
Ghana	Ahafo	Asutifi North	82,422	78,485	5.0%
Ghana	Ahafo	Asutifi South	75,450	71,846	5.0%
Ghana	Ahafo	Tano North	105,149	100,127	5.0%
Ghana	Ahafo	Tano South	97,474	92,819	5.0%
Ghana	Ashanti	Adansi Akrofu	54,612	52,221	4.6%
Ghana	Ashanti	Adansi Asokwa	79,599	76,114	4.6%
Ghana	Ashanti	Adansi North	60,001	57,374	4.6%
Ghana	Ashanti	Adansi South	94,397	90,264	4.6%
Ghana	Ashanti	Afigya Kwabre I	81,245	77,688	4.6%
Ghana	Ashanti	Afigya Kwabre S	259,997	248,616	4.6%
Ghana	Ashanti	Ahafo Ano Nor	102,753	98,254	4.6%
Ghana	Ashanti	Ahafo Ano Sou	70,320	67,240	4.6%
Ghana	Ashanti	Ahafo Ano Sou	72,870	69,678	4.6%

Step-by-Step Walkthrough: Step 5

Trace AI outputs to original cells

Reading the file:

- Flags row-level evidence for findings, IU match, demographics, endemicity, PC required, and scope
- Shows TRUE/FALSE indicators so missing or incomplete evidence is easy to spot by filtering
- Records the source row and source cell range for verification
- Lets reviewers trace each computed output back to the original workbook cells

AutoSave

Off

Save

Undo

Redo

File Edit View Insert Format Load Cell Help

Search

File Home Insert Draw Page Layout Formulas Data Review View Automate Help

Clipboard

Font

Alignment

Number

Styles

Cells

Editing

Add-ins

Comments

Share

1

Population requiring PC

Administration			Traceability							
Country	Province/State	District	has_findings	has_iu_match_finding	has_demographic_finding	has_endemicity_finding	has_pc_requirement_finding	has_scope_finding	source_row	source_cell_range
Ghana	Ahafo	Asunafo North	TRUE	FALSE	TRUE	FALSE	FALSE	FALSE	10	COUNTRY_INFO!A10:U10
Ghana	Ahafo	Asunafo South	TRUE	FALSE	TRUE	FALSE	FALSE	FALSE	11	COUNTRY_INFO!A11:U11
Ghana	Ahafo	Asutifi North	TRUE	FALSE	TRUE	FALSE	TRUE	FALSE	12	COUNTRY_INFO!A12:U12
Ghana	Ahafo	Asutifi South	TRUE	FALSE	TRUE	FALSE	TRUE	FALSE	13	COUNTRY_INFO!A13:U13
Ghana	Ahafo	Tano North	TRUE	FALSE	TRUE	FALSE	TRUE	FALSE	14	COUNTRY_INFO!A14:U14
Ghana	Ahafo	Tano South	TRUE	FALSE	TRUE	FALSE	FALSE	FALSE	15	COUNTRY_INFO!A15:U15
Ghana	Ashanti	Adansi Akrofuor	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	16	COUNTRY_INFO!A16:U16
Ghana	Ashanti	Adansi Asokwa	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	17	COUNTRY_INFO!A17:U17
Ghana	Ashanti	Adansi North	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	18	COUNTRY_INFO!A18:U18
Ghana	Ashanti	Adansi South	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	19	COUNTRY_INFO!A19:U19
Ghana	Ashanti	Afigya Kwabre N	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	20	COUNTRY_INFO!A20:U20
Ghana	Ashanti	Afigya Kwabre Se	TRUE	FALSE	FALSE	TRUE	TRUE	FALSE	21	COUNTRY_INFO!A21:U21
Ghana	Ashanti	Ahafo Ano North	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	22	COUNTRY_INFO!A22:U22
Ghana	Ashanti	Ahafo Ano Sout	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	23	COUNTRY_INFO!A23:U23
Ghana	Ashanti	Ahafo Ano Sout	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	24	COUNTRY_INFO!A24:U24
Ghana	Ashanti	Amansie Centra	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	25	COUNTRY_INFO!A25:U25
Ghana	Ashanti	Amansie South	TRUE	FALSE	FALSE	TRUE	TRUE	FALSE	26	COUNTRY_INFO!A26:U26
Ghana	Ashanti	Amansie West	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	27	COUNTRY_INFO!A27:U27

< >

INTRO

COUNTRY_INFO

ALB_MBD

IU_MATCH

DEMOGRAPHICS

ENDEMICI

...

+

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◀

Step-by-Step Walkthrough: Step 5

Review IU lists

Reading the file:

Reviews workbook districts against the JRSM IU directory and shows the suggested IU match.

- Lists workbook ADM1/district values
- Shows suggested IU ID and IU name
- Flags rows needing review when the match is not clear

IU / district match review							
review_status	source_row	workbook_adm1	workbook_district	suggested_iu_id	suggested_iu_name	suggested_adm1	suggested_adm2
no finding	10	Ahafo	Asunafo North	21408	Asunafo North	Ahafo	Asunafo North
no finding	11	Ahafo	Asunafo South	21409	Asunafo South	Ahafo	Asunafo South
no finding	12	Ahafo	Asutifi North	21411	Asutifi North	Ahafo	Asutifi North
no finding	13	Ahafo	Asutifi South	21412	Asutifi South	Ahafo	Asutifi South
no finding	14	Ahafo	Tano North	21432	Tano North	Ahafo	Tano North
no finding	15	Ahafo	Tano South	21433	Tano South	Ahafo	Tano South
no finding	16	Ashanti	Adansi Akrofuom	21622	Adansi Akrofuom	Ashanti	Adansi Akrofuom
no finding	17	Ashanti	Adansi Asokwa	21604	Adansi Asokwa	Ashanti	Adansi Asokwa
no finding	18	Ashanti	Adansi North	21605	Adansi North	Ashanti	Adansi North
no finding	19	Ashanti	Adansi South	21380	Adansi South	Ashanti	Adansi South
no finding	20	Ashanti	Afigya Kwabre North	21606	Afigya Kwabre North	Ashanti	Afigya Kwabre North
no finding	21	Ashanti	Afigya Kwabre South	21607	Afigya Kwabre South	Ashanti	Afigya Kwabre South
no finding	22	Ashanti	Ahafo Ano North	21382	Ahafo-Ano North	Ashanti	Ahafo Ano North
no finding	23	Ashanti	Ahafo Ano South East	21609	Ahafo Ano South East	Ashanti	Ahafo Ano South East
no finding	24	Ashanti	Ahafo Ano South West	21608	Ahafo Ano South West	Ashanti	Ahafo Ano South West
no finding	25	Ashanti	Amansie Central	21384	Amansie Central	Ashanti	Amansie Central
no finding	26	Ashanti	Amansie South	21610	Amansie South	Ashanti	Amansie South

Next Steps

1. Explore the JRSM workflow using your own submissions!
2. Provide feedback for areas such as:
 - a. Interaction steps
 - b. Output file
 - c. Understanding the chatbot message

Please fill this [Google survey form](#) after your testing!

Thank You



TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING
NTD Data Use, Reporting and Supply Chain
Capacity

Kintélé, Brazzaville,
Republic of the Congo

DAY 3



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING

NTD Data Use, Reporting and Supply Chain Capacity

Step-by-step guide for completing the JAP

Kintélé, Brazzaville,
Republic of the Congo



TRAINING WORKSHOP ON EFFECTIVE PC- NTDS DATA PROCESSING NTD Data Use, Reporting and Supply Chain Capacity

**Step-by-step guide for
completing the JAP**

JRSM and JRF



What is a good quality **treatment report**?

1. Justifiable

- ✓ **Demographic data is the most recent reliable data available during the MDA time**
- ✓ **Endemicity status for each district is consistent with the epidemiological data used to plan and implement MDA**
- ✓ **Population requiring PC is adjusted to the area of disease transmission**
- ✓ The PC strategies implemented have been selected for each district
- ✓ The Number of treatment rounds for each disease is consistent with the implemented MDA
- ✓ **The number of people targeted and treated by age group are provide**
- ✓ The medicine used for STH is specified (ALB/MBD)

2. Completeness

- ✓ **Data from all treated communities are included and have been verified**
- ✓ Inventory of medicines available in the country is reported (tablets received, distributed, expired, lost, remaining, ...)
- ✓ **Provide any additional relevant information that could help the reader in interpreting the data**

The Joint Application Package: four forms, one package

JRSM

Joint Request for Selected PC Medicines

Medicine quantification

How many tablets are needed to reach the planned target population and districts.

By implementation unit

JRF

Joint Reporting Form

Treatment coverage

How many people were treated with each regimen, by age group and by IU.

By implementation unit

EPIRF

PC Epidemiological Data Reporting Form

Survey results

Epidemiological results of surveys for LF, ONCHO, STH and SCH.

By survey site

AWP

Annual Work Plan

Activities and financing

Objectives, activities, costs, committed funds and funding gap for the year.

By country

Today's focus: the JRF — what was actually implemented and how many people were treated.

Deadlines for submission of the JAP forms

JRF

Within 3 months after the last MDA round was implemented — and no later than 31 March of the next implementation year.

Example

*Last MDA round completed in April 2024
→ JRF 2024 submitted no later than July 2024.*

JRSM

At least 9 months before the first date of MDA planned in the calendar year of the request.

Example

*First MDA round planned in May 2026
→ JRSM 2026 submitted no later than August 2025.*

EPIRF

As soon as a specific survey is completed — one EPIRF per survey (ESPEN recommendation).

Example

*LF TAS1 completed in May 2025 → EPIRF by June 2025.
SCH impact assessment in August 2025 → a separate EPIRF by September 2025.*

A late form delays medicine delivery for the next round — the three deadlines are independent of each other.

Completing the JRF

PC Joint Reporting Form v.4.5 — worksheet by worksheet, from
INTRO to SUMMARY.

PC Joint Reporting Form v.4.5

The purpose of this template **Joint Reporting Form (JRF)** - available as an Excel file - is to provide national health authorities and data managers with a standardized tool to address these reporting challenges, facilitate integration and thereby further contribute to improving overall programme management. This template aims to standardize national reporting of programme implementation outcomes, improve availability and coordination of preventive chemotherapy data across the World Health Organization regions.

National authorities are requested to complete this form for submission to the World Health Organization **within 3 months** after the last round was implemented and **no later than 31 March** of the next implementation year.

Structure of the application (worksheets):

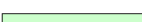
INTRO	This worksheet includes guides on how to complete the joint reporting form and information about status of PC for endemic diseases in the country
COUNTRY_INFO	This worksheet includes information about administrative structure of the country, population by age group, status of endemicity for each disease, population requiring PC, planned interventions and interventions implemented
MDA1, MDA2, MDA3, MDA4, MDA5, T1, T2 and T3	These worksheets include information about endemic districts targeted for treatment with specified PC medicines, treatment plan, and number of people who received treatment by age group. Depending on co-endemicity of the diseases in a country the tool will generate respective worksheets to fill in.
DISTRICT	This worksheet includes summary of people treated by disease at the level of implementation. If data by gender is available, it requires to enter.
SUMMARY	This worksheet includes summary of people treated by disease and by PC intervention. Before generating the report (run macros) please select the disease for which you need the report. Follow the same rule to generate various reports. This worksheet should be printed and submitted as a Joint Report (see the instruction for submission in the SUMMARY worksheet).

Instruction for data entry

Most of the cells in the above-mentioned worksheets include formula that are calculated automatically according to the treatment policy recommended by WHO for each disease.

See the link <https://www.who.int/publications/i/item/9789241599993>

Please enter your data into the cells according to their colour code:

	White - cell is not protected. Please enter the value of the requested indicator.
	Yellow - cell is protected and includes name of indicator. No data entry required.
	Orange - cell is not protected and includes a drop-down menu. Please select the value from the drop-down list.
	Green - cell is not protected and includes formula. Please change the value only if your data are different from those that are calculated automatically.
	Blue - cell is protected and includes formula. No data entry required.

The JRF opens with its own INTRO sheet

Report by treatment regimen — not by disease

! VERY IMPORTANT

Treatment figures are not entered as the number of persons treated per single disease.

You enter the number of persons who received each type of treatment regimen — that is, each drug package.

The form then allocates those persons to the different diseases automatically.

Treatment regimens (PC strategy) and the diseases they reach

MDA1

IVM + ALB

LF

ONC

STH

T1

PZQ + ALB/MBD

SCH

STH

MDA2

DEC + ALB

LF

STH

T3

ALB/MBD alone

STH

MDA3

IVM alone

ONC

T2

PZQ alone

SCH

MDA4

ALB × 2

LF

STH

MDA5

IVM + DEC + ALB

LF

STH

Four worksheets, in this order

1 INTRO

Same as the JRSIM

- Status of the 4 PC-NTDs in the country
- Name of the implementation units (IUs)
- Proportion of each age group (PreSAC, SAC, Adults, WRA)
- Generate the required worksheets

2 COUNTRY_INFO

One line per IU

- Demography: total population and population by age group
- Endemicity status for each disease
- Population requiring PC for ONCHO and SCH
- PC strategy implemented (MDA1–MDA5, T1–T3)
- Actual number of rounds implemented per disease

3 MDA & T sheets

MDA1–5, T1, T2, T3

- Date of MDA and medicine used
- Target population, by age group
- Number of persons treated, by age group
- Programmatic coverage is computed for you

4 SUMMARY

Print and submit

- Generate the report (run the macro)
- Provide the complementary information
- Print, sign and submit to WHO

Only the worksheets matching the strategies you declared in COUNTRY_INFO are generated — the form adapts to your country.

INTRO — set the scene before anything else

 **Joint request for selected PC medicines v.4.0**

As part of global efforts to accelerate expansion of preventive chemotherapy (PC) for control and elimination of lymphatic filariasis, schistosomiasis and soil-transmitted helminthiases, the World Health Organization (WHO) facilitates the supply of albendazole 400 mg tablets (GSK) to national lymphatic filariasis elimination programmes and national soil-transmitted helminth control programmes; diethylcarbamazine citrate 100 mg tablets (Erisa) to national lymphatic filariasis elimination programmes; mebendazole 500 mg tablets (J&J) for national soil-transmitted helminth control programmes; and praziquantel 600 mg tablets (Merck KGaA) for school-age children to national schistosomiasis control programmes. WHO also collaborates to supply ivermectin 3 mg tablets (Merck) for onchocerciasis and lymphatic filariasis donation programmes.

This Excel-based tool is designed to assist countries in quantifying the number of tablets of relevant PC medicines required to reach the planned target population and districts for the year of request. Output of the tool is a joint request for PC medicines, which can be printed, signed and submitted to WHO to request these medicines.

Structure of the application (worksheets):

INTRO This worksheet includes guides on how to complete the joint request for selected PC medicines and information about the status of PC for endemic diseases in the country.

COUNTRY_INFO This worksheet includes information about administrative structure of the country, population by age group, status of endemicity for each disease, population requiring PC and planned interventions.

DEC, ALB_MBD, PZQ and IVM SUMMARY These worksheets include information about endemic districts targeted for treatment with specified PC medicines, treatment plan, and number of tablets required and requested.

This worksheet includes summary of number of tablets requested, information about stock, and date for submission of requested medicines. Before generating the report (run macros) please select the medicine for which the report is needed. Follow the same rule to see the number of people to be treated for the specific disease.

This worksheet should be printed and submitted as a joint request for selected PC medicines (see the instruction for submission in the SUMMARY worksheet).

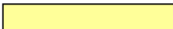
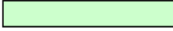
Every JAP form opens the same way

Instruction for data entry

Most of the cells in the above-mentioned worksheets include formula that are calculated automatically according to the treatment policy recommended by WHO for each disease.

See the link <https://www.who.int/publications/i/item/9789241599993>.

Please enter your data into the cells according to their colour code:

	White - cell is not protected. Please enter the value of the requested indicator.
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	Orange - cell is not protected and includes a drop-down menu. Please select the value from the drop-down list.
	Green - cell is not protected and includes formula. Please change the value only if your data are different from those that are calculated automatically.
	Blue - cell is protected and includes formula. No data entry required.

Colour code for data entry

Country data

COUNTRY	Motanga	
Year of reporting data	2023	
Is country endemic for lymphatic filariasis (LF)?	Endemic	
Is country endemic for onchocerciasis (ONCHO)?	Endemic	
Is country endemic for soil-transmitted helminthiases (STH)?	Endemic	
Is country endemic for schistosomiasis (SCH)?	Endemic	
How many administrative units in the country?	20	
If demographical data at the second administrative level are not available by age group, please enter the proportion (%) of population by age group in the country. If data are available, please leave these cells blank.		
1-4 years age	Preschool-age children (PreSAC)	10.65%
5-14 years age	School-age children (SAC)	24.71%
15 years +	Adults	61.23%
15-49 years	Women of reproductive age (WRA)	24.77%
Restore full version	Clear forms	Generate new forms

Only one tab. Until the forms are generated, INTRO is the single worksheet.

Generate new forms. The endemicity answers decide which worksheets appear.

White = enter data · Yellow = protected label · Orange = drop-down · Green = formula, change only if your data differ · Blue = protected formula

INTRO — country data in the JRF

Country data

COUNTRY	Motanga
Year of reporting data	2023
Is country endemic for lymphatic filariasis (LF) ?	Endemic
Is country endemic for onchocerciasis (ONCHO) ?	Endemic
Is country endemic for soil-transmitted helminthiases (STH) ?	Endemic
Is country endemic for schistosomiasis (SCH) ?	Endemic
How many administrative units in the country?	20
If demographical data at the second administrative level are not available by age group, please enter the proportion (%) of population by age group in the country. If data are available, please leave these cells blank.	
1-4 years age	Preschool-age children (PreSAC) 10.65%
5-14 years age	School-age children (SAC) 24.71%
15 years +	Adults 61.23%
15-49 years	Women of reproductive age (WRA) 24.77%

Restore full version

Clear forms

Generate new forms

< >

INTRO

COUNTRY_INFO

MDA1

MDA3

MDA4

T1

T2

T3_R1

T3_R2

T3_R3

DISTRICT

SUMMAR

Same as the JRSM. Once the forms are generated, the worksheets you need appear as tabs at the bottom of the file.

COUNTRY_INFO — one line per implementation unit

1

COUNTRY INFORMATION

Administrative structure, population by age group, endemicity status, planned interventions and interventions implemented

TOTAL	7,661,890	816,218	1,893,514	4,691,650	
Country administrative structure	Population				
Province/State	District	Total	PreSAC	SAC	Adults
SYBIL	Westhall	168,443	17,944	41,628	103,144
SYBIL	Angeal	176,077	18,757	43,515	107,818
SYBIL	Keyside	81,006	8,630	20,019	49,603
SYBIL	Nox	185,800	19,793	45,918	113,772
SYBIL	Southwark	863,672	92,007	213,443	528,857
SYBIL	Quintus	846,160	90,141	209,115	518,134
ZOMEA	Tuskenvale	234,921	25,026	58,057	143,851
ZOMEA	Malunbag	254,721	27,135	62,950	155,975
ZOMEA	Princeton	363,342	38,707	89,794	222,487
ZOMEA	Huwen	367,380	39,137	90,792	224,960
ZOMEA	Camden	611,600	65,154	151,147	374,505
ZOMEA	Aralas	269,174	28,675	66,522	164,825
ZOMEA	Grafburg	348,111	37,084	86,030	213,161
ZOMEA	Luthya	435,712	46,416	107,679	266,802
ZOMEA	Findre	878,767	93,615	217,173	538,101
ZOMEA	Roscoff	341,689	36,400	84,443	209,228

2

Estimate population for SCH by age group		
Validation	Undo	
3		
Number of treatment rounds implemented in		
PC implemented		
ROUND 1	ROUND 2	ROUND 3

3

LF	ONCHO	PreSAC	SAC	WRA	TOTAL	PreSAC	SAC	Adults	TOTAL
168,443	168,443	0	0	0	0	13,458	41,628	103,144	158,230
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	69,005	213,443	528,857	811,305
0	0	0	0	0	0	67,606	209,115	518,134	794,855
234,921	234,921	0	0	0	0	18,770	58,057	143,851	220,678
Stopped	254,721	0	0	0	0	20,351	62,950	155,975	239,276
363,342	363,342	38,707	89,794	90,010	218,511	29,030	89,794	222,487	341,311
367,380	367,380	39,137	90,792	91,011	220,940	29,353	90,792	224,960	345,105
611,600	611,600	65,154	151,147	151,511	367,812	48,866	151,147	374,505	574,518
Stopped	269,174	28,675	66,522	66,682	161,879	21,506	66,522	164,825	252,853
348,111	348,111	37,084	86,030	86,237	209,351	27,813	86,030	213,161	327,004
435,712	435,712	46,416	107,679	107,938	262,033	0	0	0	0
878,767	878,767	0	0	0	0	70,211	217,173	538,101	825,485
0 Unknown	0	0	0	0	0	0	0	0	0

4

Validation	Undo	
3		
Number of treatment rounds implemented in		
PC implemented		
ROUND 1	ROUND 2	ROUND 3

5

ROUND 1	ROUND 2	ROUND 3
IDA1 (IVM+ALB)	T1 (PZQ+ALB/MBD)	
IDA1 (IVM+ALB)		
MDA3 (IVM)	T2 (PZQ)	
IDA1 (IVM+ALB)	T1 (PZQ+ALB/MBD)	
IDA1 (IVM+ALB)	T1 (PZQ+ALB/MBD)	
IDA1 (IVM+ALB)	T1 (PZQ+ALB/MBD)	
MDA3 (IVM)	T1 (PZQ+ALB/MBD)	
IDA1 (IVM+ALB)	T1 (PZQ+ALB/MBD)	
MDA3 (IVM)	T3 (ALB/MBD)	
IDA1 (IVM+ALB)	T2 (PZQ)	

1 IUs with demography

Total population and population by age group

2 Endemicity status

For LF, ONC, STH, SCH (and Loa loa)

3 Population requiring PC

ONCHO and SCH — adjust to the transmission zone

4 Rounds implemented

Actual number, per disease, in the reporting year

5 PC strategy implemented

MDA1–MDA5, T1, T2, T3 per round

Data you must have in hand

1 Date of the MDA

Month and year each round was conducted.

2 Medicine used

Which product was distributed (matters for T1 and T3).

3 Target population

By age group where available — the form can also estimate it.

4 People treated

By age group where available, otherwise the total.

5 Programmatic coverage

Computed automatically from target and treated.

6 Outlier check

Review any coverage that is implausibly low or above 100%.

Coverage above 100% usually means a denominator problem, not an over-performance — check the target population first.

MDA1 — target, treated, coverage

MDA 1 - Ivermectin (IVM) and Albendazole (ALB)																
Administrative structure, population requiring PC by age group, population treated by age group and coverage									Estimate by age group				Data validation			
TOTAL					Run MDA1 macro											
Country administrative structure					PC implemented				Date							
Country	Province/State	District			Population targeted for MDA 1				Population treated				Programme coverage (%)			
					PreSAC	SAC	Adults	Total	PreSAC	SAC	Adults	Total	PreSAC	SAC	Adults	Total
Motanga	SYBIL	Barking														
Motanga	SYBIL	Vonvlees														
Motanga	SYBIL	Ashpoint														
Motanga	SYBIL	Purstmarch	MDA1 (IVM+ALB)			62,048	153,739	215,787		58,354	115,921	174,275		94.05	75.40	80.76
Motanga	SYBIL	Westhall	MDA1 (IVM+ALB)			41,628	103,144	144,772		44,965	78,500	123,465		108.02	76.11	85.28
Motanga	SYBIL	Anngeal														
Motanga	SYBIL	Keyside														
Motanga	SYBIL	Nox														
Motanga	SYBIL	Southwark														
Motanga	SYBIL	Quintus														
Motanga	ZOMEA	Tuskenvale	MDA1 (IVM+ALB)			58,057	143,851	201,908		69,170	118,389	187,559		119.14	82.30	92.89
Motanga	ZOMEA	Malunbag														
Motanga	ZOMEA	Princeton	MDA1 (IVM+ALB)			89,794	222,487	312,281		83,663	146,949	230,612		93.17	66.05	73.85
Motanga	ZOMEA	Huwen	MDA1 (IVM+ALB)			90,792	224,960	315,752		84,321	146,837	231,158		92.87	65.27	73.21
Motanga	ZOMEA	Camden	MDA1 (IVM+ALB)			151,147	374,505	525,652		113,201	306,292	419,493		74.89	81.79	79.80
Motanga	ZOMEA	Aralas														
Motanga	ZOMEA	Grafburg	MDA1 (IVM+ALB)			86,030	213,161	299,191		88,771	149,148	237,919		103.19	69.97	79.52
Motanga	ZOMEA	Luthya														
Motanga	ZOMEA	Findre	MDA1 (IVM+ALB)			217,173	538,101	755,274		274,633	425,734	700,367		126.46	79.12	92.73
Motanga	ZOMEA	Roscoff														

Estimate by age group

Use these buttons when only the total is available — for the target population and for the people treated.

Target population

Number of people planned to be treated in the year.

Persons treated

By age group, or total only where that is all you have.

Programme coverage

% of the target population treated.

T1 — praziquantel with albendazole or mebendazole

T 1 - Praziquantel (PZQ) and Albendazole (ALB) or Mebendazole (MBD)															
Administrative structure, population requiring PC by age group, population treated by age group and coverage															
Data validation Undo															
TOTAL	Run T1 macro			170,026	525,913	1,303,082	1,999,021		488,772		488,772	-	92.94	-	24.45
Country administrative s	PC implemented	Medicine	Date	Population targeted for T1				Population treated				Programme coverage (%)			
(Province/District)				PreSAC	SAC	Adults	Total	PreSAC	SAC	Adults	Total	PreSAC	SAC	Adults	Total
SYBIL Barking															
SYBIL Vonvlees															
SYBIL Ashpoint															
SYBIL Purstmarch															
SYBIL Westhall	T1 (PZQ+ALB/MBD)	PZQ+ALB	Sept-2023	13,458	41,628	103,144	158,230		44,965		44,965	-	108.02	-	28.42
SYBIL Anngeal															
SYBIL Keyside															
SYBIL Nox															
SYBIL Southwark															
SYBIL Quintus															
ZOMEA Tuskenvale															
ZOMEA Malunbag															
ZOMEA Princeton	T1 (PZQ+ALB/MBD)	PZQ+ALB	Déc-2023	29,030	89,794	222,487	341,311		83,663		83,663	-	93.17	-	24.51
ZOMEA Huwen	T1 (PZQ+ALB/MBD)	PZQ+ALB	Déc-2023	29,353	90,792	224,960	345,105		84,321		84,321	-	92.87	-	24.43
ZOMEA Camden	T1 (PZQ+ALB/MBD)	PZQ+ALB	Sept-2023	48,866	151,147	374,505	574,518		113,201		113,201	-	74.89	-	19.70
ZOMEA Aralas	T1 (PZQ+ALB/MBD)	PZQ+ALB	Sept-2023	21,506	66,522	164,825	252,853		73,851		73,851	-	111.02	-	29.21
ZOMEA Grafburg	T1 (PZQ+ALB/MBD)	PZQ+ALB	Sept-2023	27,813	86,030	213,161	327,004		88,771		88,771	-	103.19	-	27.15
ZOMEA Luthyia															
ZOMEA Findre															
ZOMEA Roscoff															

Medicine column: record whether the package was PZQ + ALB or PZQ + MBD — the medicine reported here must match what was actually distributed.

T3 — albendazole or mebendazole alone, round by round

One worksheet per round

T3_R1, T3_R2, T3_R3 — deworming is often delivered more than once a year.

Check the medicine

ALB and MBD are reported separately.

T 3 - Albendazole (ALB) or Mebendazole (MBD)				Select medicine used for treatment of STH for each age group		Estimate by age group		Data validation		Undo						
Administrative structure, population requiring PC by age group, population treated by age group				MBD	ALB	Select the category of Adults										
TOTAL				Run T3 macro	46,416	107,679	107,938	262,033	22,402	22,402	-	20.80	-	8.55		
Country administrative structure			PC implemented	Date	Population targeted for T3				Population treated				Programme coverage (%)			
Country	Province/District				PreSAC	SAC	Adults	Total	PreSAC	SAC	Adults	Total	PreSAC	SAC	Adults	Total
Motanga	SYBIL	Barking														
Motanga	SYBIL	Vonvees														
Motanga	SYBIL	Ashpoint														
Motanga	SYBIL	Purstmarch														
Motanga	SYBIL	Westhall														
Motanga	SYBIL	Angeal														
Motanga	SYBIL	Keyside														
Motanga	SYBIL	Nox														
Motanga	SYBIL	Southwark														
Motanga	SYBIL	Quintus														
Motanga	ZOMEA	Tuskenvale														
Motanga	ZOMEA	Malunbag														
Motanga	ZOMEA	Princeton														
Motanga	ZOMEA	Huwen														
Motanga	ZOMEA	Camden														
Motanga	ZOMEA	Aralas														
Motanga	ZOMEA	Grafburg														
Motanga	ZOMEA	Luthyia	T3 (ALB/MBD)		46,416	107,679	107,938	262,033	22,402			22,402	-	20.80	-	8.55
Motanga	ZOMEA	Findre														
Motanga	ZOMEA	Roscoff														

SUMMARY — generate, complete, submit

 World Health Organization

The current version should be used in countries endemic for Loiasis

PC Joint Reporting Form v.4.2 (Loa)

Country Motanga **Year** 2023

National authorities are requested to complete the **Joint Reporting Form (JRF)** for submission to the World Health Organization **within 3 months** after the last round was implemented and **no later than 31 March** of the next implementation year.

[Click here](#) [Generate Report](#) [Click here](#)

Number of people received treatment (at least once) for the diseases (all areas) and geographical coverage (%)

	PreSAC	SAC	Adults	Total	Geographical
Lymphatic filariasis		817,078	1,487,770	2,304,848	100.00
Onchocerciasis	Not eligible	979,077	1,764,835	2,743,912	100.00
Soil-transmitted helminthiasis		913,331	1,487,770	2,401,101	100.00
Schistosomiasis		887,443		887,443	75.00

Number of people in need (in areas requiring PC) received treatment for the diseases and national coverage (%)

	PreSAC	SAC	Adults	Total	National
Lymphatic filariasis				1,366,562	37.34
Onchocerciasis	Not eligible	979,077	1,764,835	2,743,912	65.59
Soil-transmitted helminthiasis		456,139	418,769	874,908	60.74
Schistosomiasis		813,842		813,842	15.88

Number of people treated by PC intervention and programme coverage (%)

	PreSAC	SAC	Adults	Total	Programme
MDA 1 (IVM+ALB)	Not eligible	817,078	1,487,770	2,304,848	83.19
MDA 3 (IVM)	Not eligible	161,999	277,065	439,064	53.24
MDA 4 (ALB/2*ALB)					
T 1 (PZQ+ALB/MBD)	Not targeted	488,772	Not targeted	488,772	24.45
T 2 (PZQ)		398,671		398,671	30.65
T 3 (ALB/MBD) - round 1		22,402		22,402	8.55
T 3 (ALB/MBD) - round 2					
T 3 (ALB/MBD) - round 3					

Inventory of PC medicines in the country

	IVM	DEC	ALB (LF)	ALB (STH)	MBD	PZQ
Available						
Distributed						
Wasted						
Received						
Remaining						

Please indicate the medicine has been used to treat PreSAC for STH and delivery channels

PC medicine	Delivery channels	Source

Additional information

[Read Statement](#) [Read before submission](#)

I have read and accept WHO Data Sharing Policy ☒

I confirm that all information provided in this form is complete and correct ☒

Name and signature of NTD coordinator or Ministry of Health representative: _____

Date: _____

Please send the national report (signed and in electronic format) to the concerned WR with copy to:

WHO headquarters PC_JointForms@who.int
 WHO Regional Office Regional Advisor for NTD

[Save Report in EXCEL](#) [Save Report in PDF](#) [Generate Country Profile](#) [Print Report](#)

1 Run the macro

Select the disease you want reported, then generate — repeat for each disease.

2 Complete the data-sharing section

Confirm the WHO data-sharing policy and the contact details.

3 Print, sign, submit

The SUMMARY sheet is the sheet that is submitted as the joint reporting form.

Country profile — what the form gives back to you

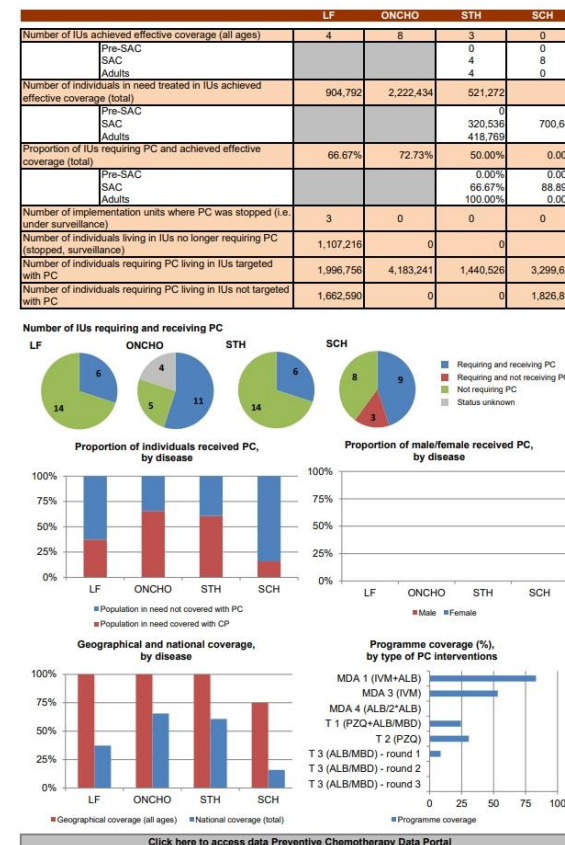
The profile is generated from the data you entered — a quick way to spot an implausible figure before you submit.



PC Joint Reporting Form v.4.2 - Country Profile

Country	Motanga		Year	2023
!!! WARNING !!!				
Before analysing data in the country profile please be ensure that your report in the SUMMARY tab is updated				
Total population		100%	7,661,890	
Population — other age groups		3.40%	260,508	
Population — Pre-SAC	1-4 years age	10.65%	816,218	
Population — SAC	5-14 years age	24.71%	1,893,514	
Population — Adults	15 years +	61.23%	4,691,650	
Total number of people requiring PC for at least one disease (LF, ONCHO, STH, SCH)				
			5,789,402	
Proportion of number of people requiring PC for at least one disease out of total population				
			75.56%	
Number of IUs requiring PC for at least one disease (LF, ONCHO, STH, SCH)				
			13	
Number of IUs received PC for at least one disease (LF, ONCHO, STH, SCH)				
			11	
Proportion of IUs requiring PC for at least one disease and received it				
			84.52%	
Total number of people received PC for at least one disease (LF, ONCHO, STH, SCH)				
			2,743,912	
Total number of people in need who received PC for at least one disease (LF, ONCHO, STH, SCH)				
			2,659,136	
Coverage of PC for at least one disease (LF, ONCHO, STH, SCH)				
			45.93%	
Number of IUs received treatment for all diseases requiring PC in those IUs				
			2,285,730	
Population requiring PC in IUs which received treatment for all diseases in need of PC				
			1,544,897	
Population in need received PC in IUs which were treated for all diseases in need of PC				
	LF	ONCHO	STH	SCH
Diseases requiring PC in the country	Yes	Yes	Yes	Yes
Number of implementation units (IUs) in the country	20	20	20	20
Number of IUs with endemicity status known	0	4	0	0
Number of non-endemic IUs	8	5	0	3
Number of IUs requiring PC (total)	6	11	6	12
baseline prevalence			6	12
impact prevalence			0	0
- low			0	0
Population requiring PC in the country (total)	3,659,346	4,183,241	1,440,526	5,126,467
1-1 year old	124,419	142,232		436,029
Pre-SAC	389,829	445,639	255,173	1,348,699
SAC	904,348	1,033,821	591,964	3,341,739
Adults	2,240,750	2,561,548	593,389	
Population requiring PC in low impact prevalence areas				
Number of IUs where PC was implemented (total)	8	11	10	9
Pre-SAC			0	0
SAC			6	9
Adults			4	0
Number of individuals treated (total)	2,304,848	2,743,912	2,401,101	887,443
Pre-SAC	0	Not eligible	0	0
SAC	817,078	979,077	913,331	887,443
Adults	1,487,770	1,764,835	1,487,770	0
Number of individuals in need treated (total)	1,386,562	2,743,912	874,969	813,842
Pre-SAC	0	Not eligible	0	0
SAC	0	979,077	456,139	813,842
Adults	0	1,764,835	418,769	0
Geographical coverage (all ages)	100.00%	100.00%	100.00%	75.00%
Pre-SAC			0.00%	0.00%
SAC			100.00%	75.00%
Adults			66.67%	0.00%
National coverage (total)	37.34%	65.59%	69.74%	15.88%
Pre-SAC			0.00%	0.00%
SAC			77.06%	60.34%
Adults			70.57%	0.00%

Coverage and treatment tables



Charts by disease and age group

Exercise — fill the JRF 2026 for Motanga

THE COUNTRY

Motanga is endemic for LF, ONC, STH and SCH.
It is not endemic for *Loa loa*.

PC strategies implemented in 2026, in different IUs:

MDA1

MDA3

T1

T2

T3

Loa loa co-endemicity changes what can be distributed — keep it in mind when you read the IU lines.

IN THE EXCEL FILE, PER IU

- Proportion of the population by age group
- Endemicity status for LF, ONC, STH, SCH and *Loa loa*
- Total population
- Population requiring PC for ONCHO (column CQ) and SCH (columns CL to CO)
- Number of people treated by age group
- For MDA3, only the total number treated is available

YOUR TASKS

1

Using the information in the Excel file, populate the JRF 2026.

2

Estimate by age group wherever only a total is given.

3

If you submitted this report today, would it be a timely or a delayed submission?

Latest JAP templates: <https://www.who.int/teams/control-of-neglected-tropical-diseases/interventions/strategies/preventive-chemotherapy/joint-application-package/>



THANK YOU

Questions on the JRF? Bring them to the hands-on session.



•THANK
•YOU



DFPC

Health Promotion,
Disease Prevention and
Control Cluster



ESPE

EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

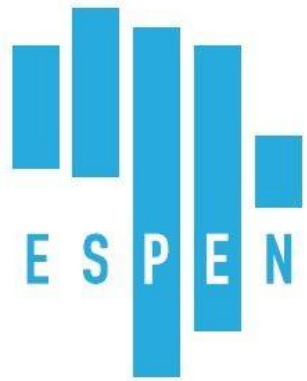


TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING NTD Data Use, Reporting and Supply Chain Capacity

Kintélé, Brazzaville,
Republic of the Congo

Advances in Data and Analytics for
Sustaining NTD Elimination in
Africa - JAP Process Assistant





EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

Advances in Data and Analytics for Sustaining NTD Elimination in Africa - ESPEN JAP Process Assistant

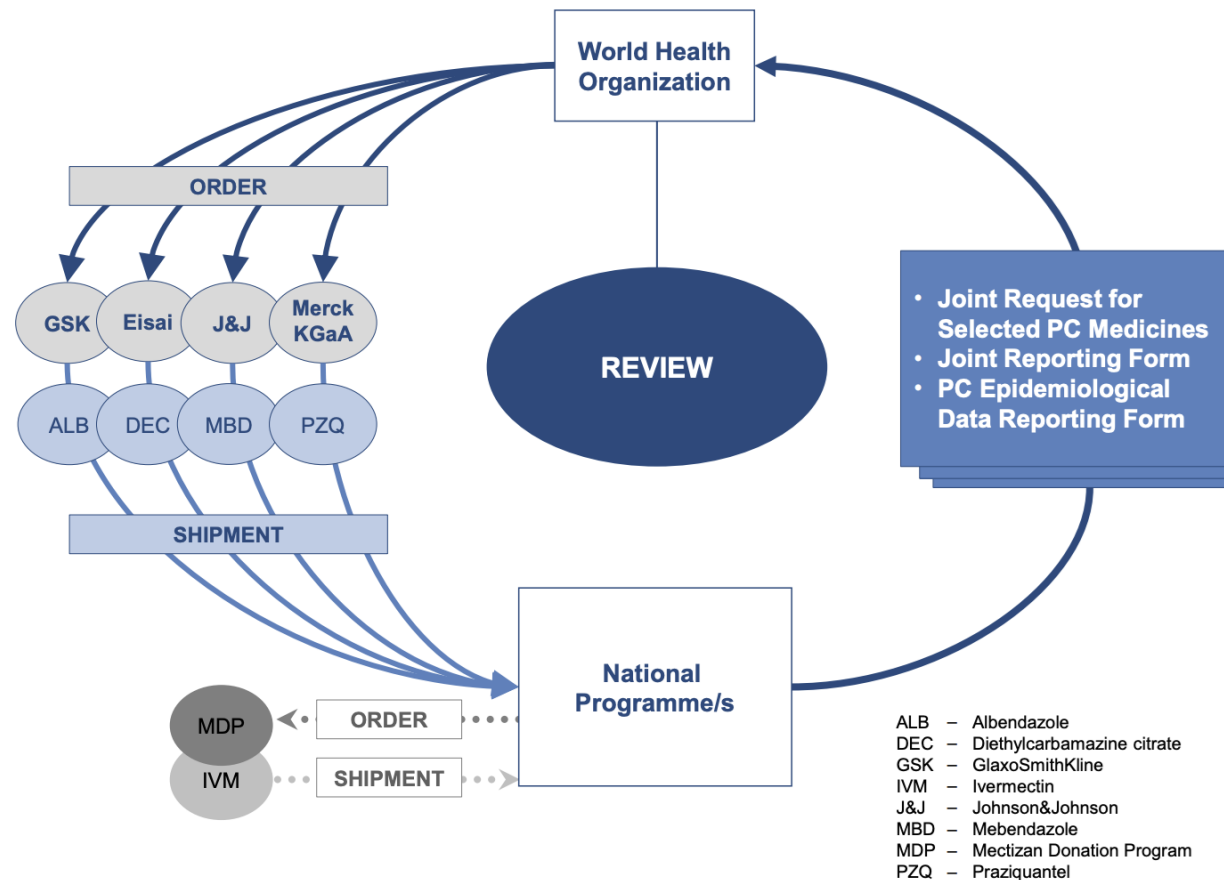
In collaboration with **dimagi**

Agenda

1. Background
 - a. What is JAP?
 - b. Background
 - c. Current State: Manual JAP Review Process
2. JAP Process Assistant Overview
3. Development and Release Phases
4. Step-by-Step Walkthrough
5. Next Steps

The JAP is how countries request donated medicines, and report treatment coverage — the PC-NTD data backbone

The Joint Application Package (JAP) Process



Background

Challenge in JAP Data Review

- Evaluating JAP submissions is traditionally a manual, time intensive process for both ESPEN and national teams.
- Reviewers frequently face challenges with formula integrity, version mismatches, and aligning data against historical database baselines.
- When a JAP is submitted with data quality issues, it delays approval process and the arrival of medicines for MDA

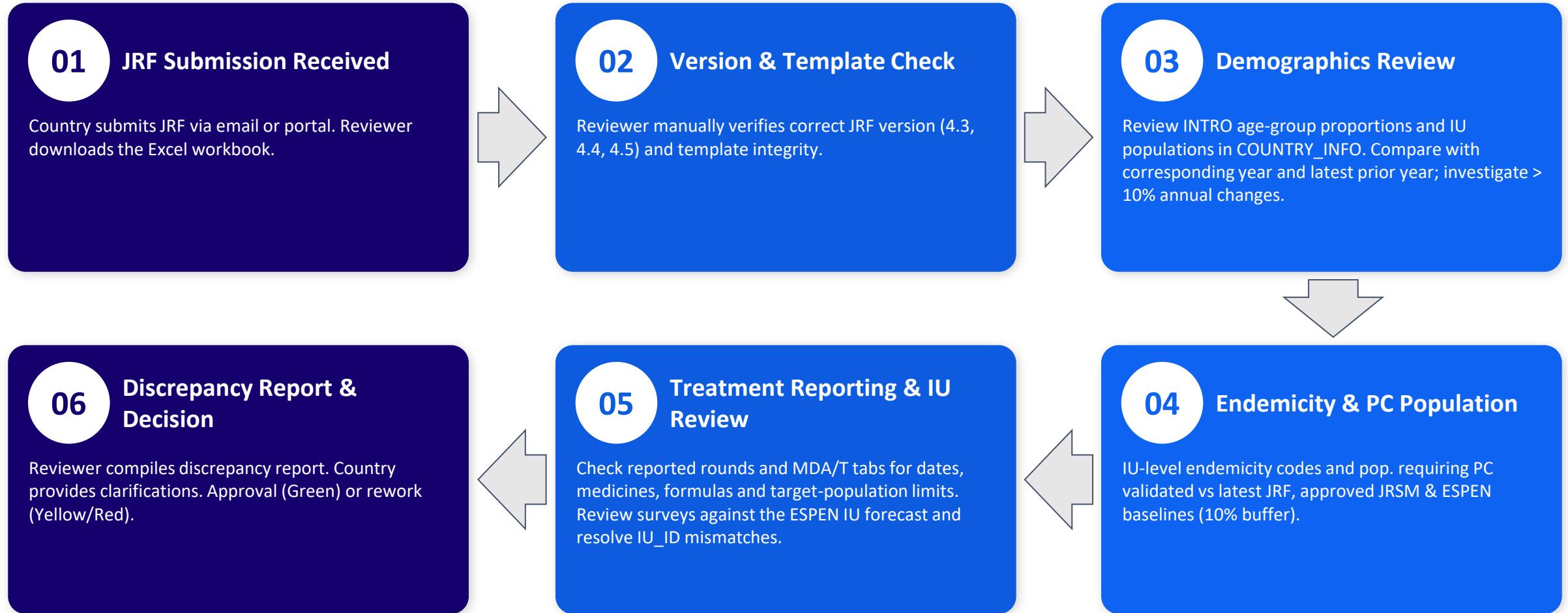
Need for JAP Automation

- A critical bottleneck exists in the feedback loop between country submissions and final approvals.
- Streamlining this process is vital to accelerate data-driven treatment decisions for sustaining NTD elimination across Africa.
- Ensure sufficient quantities of donated medicines are shipped on time for MDA implementation

Our Objective

- Introduce an AI-powered JAP Process Assistant to automate validation, flag discrepancies instantly, and provide a collaborative tool for both ESPEN and country teams to radically simplify the feedback loop.

Current State: Manual JAP Review Process



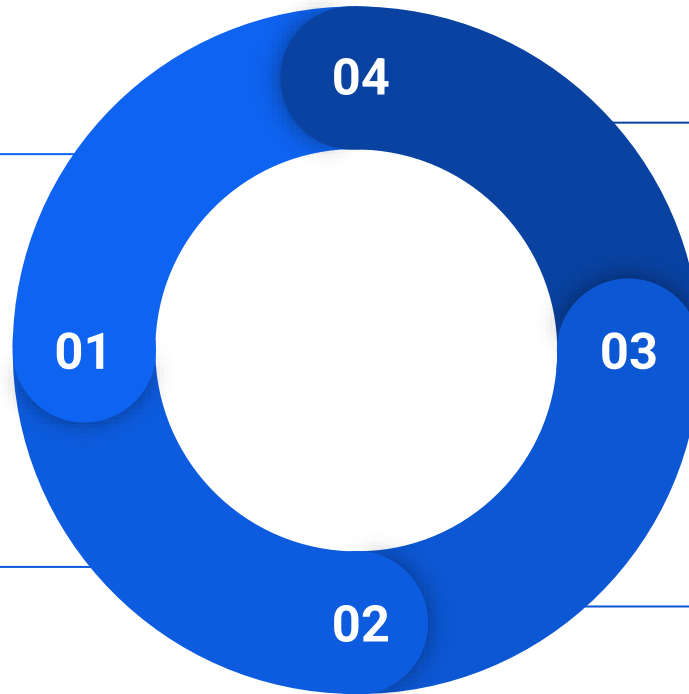
JAP Process AI Assistant

Step 1: Validation

We check if the file is the right version

Step 2: Confirmation

The tool reports back on the validation results and pauses here. The user must explicitly ask to proceed to move to the advanced computation phase.



Step 4: Final Output

CSV Exception List + LLM executive summary and draft message to submitter.

Step 3: Computation

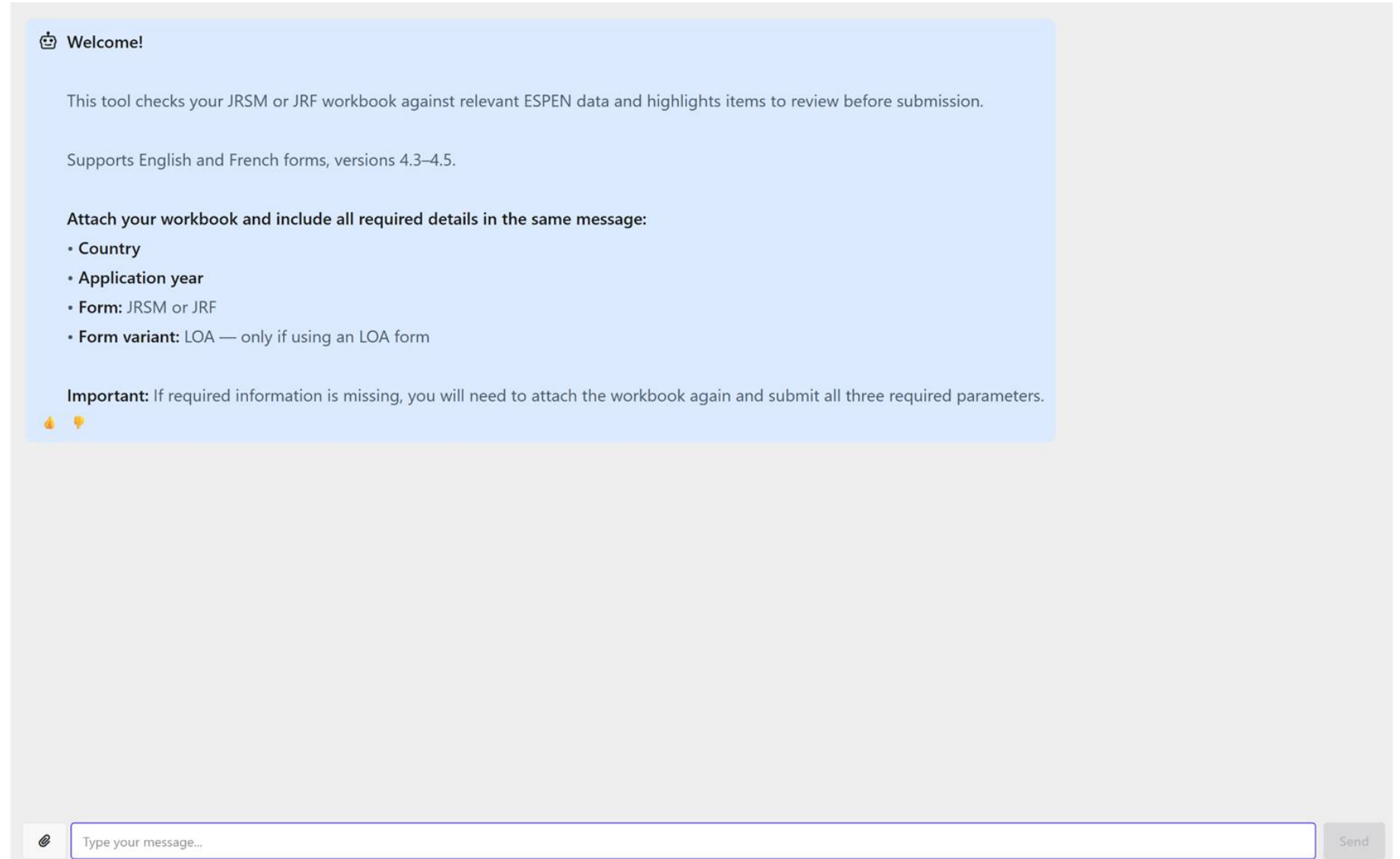
We check Formula Integrity. The tool distinguishes between protected and editable cells to ensure no formulas were broken. This is also where we run the heavy comparisons against the database baselines.

Step-by-Step Walkthrough: Step 1

Access the AI Tool

Access the tool by clicking on the following link:

<https://www.openchatstudio.com/a/ai-assistant-for-ntds/chatbots/861fcbfa-fe73-416a-8ca3-e1a0194bb050/start/>



 Welcome!

This tool checks your JRSM or JRF workbook against relevant ESPEN data and highlights items to review before submission.

Supports English and French forms, versions 4.3–4.5.

Attach your workbook and include all required details in the same message:

- Country
- Application year
- Form: JRSM or JRF
- Form variant: LOA — only if using an LOA form

Important: If required information is missing, you will need to attach the workbook again and submit all three required parameters.



 Type your message...

Send

Step-by-Step Walkthrough: Step 2

Mention the country, year of application, form type (JRF), and whether it is the LOA form variant. Then, attach the JRF form. Supported JRF versions: 4.3 - 4.5

Welcome!

This tool checks your JRSM or JRF workbook against relevant ESPEN data and highlights items to review before submission.

Supports English and French forms, versions 4.3–4.5.

Attach your workbook and include all required details in the same message:

- Country
- Application year
- Form: JRSM or JRF
- Form variant: LOA — only if using an LOA form

Important: If required information is missing, you will need to attach the workbook again and submit all three required parameters.

Upload here Type here

Angola, JRF, 2025, LOA

Send

Uploaded Files

1 JRF_2025_Angola_v45L_en_2025_05142026_1778744604 (1).xlsm

Step-by-Step Walkthrough: Step 3

Review AI summary

The tool generates an AI summary by validating the uploaded JRF form.

Type 'yes' to proceed with the computation phase.

JRF_2025_Angola_v45L_en_2025_05142026_1778744604 (1).xlsm

Executive Summary

- Several active treatment-reporting rows are missing required treatment/reporting dates across MDA and T worksheets.
- Medicine selections are missing in T1 and in the sheet-level selectors for T3_R2 and T3_R3.
- Formula preservation issues were identified in COUNTRY_INFO, with additional formula linkage concerns in SUMMARY and DISTRICT.

Priority Findings

- MDA1, MDA3, and MDA4 have missing date values across active rows where PC implementation data is populated.
- T1, T2, T3_R1, T3_R2, and T3_R3 also have missing dates on active treatment-reporting rows.
- T1 is missing medicine selector values for active treatment rows.
- T3_R2 and T3_R3 are missing sheet-level STH medicine selectors.
- COUNTRY_INFO contains formula mismatches in the LF population requiring PC calculation area.
- SUMMARY and DISTRICT include formula linkage/array-formula preservation issues that may affect workbook integrity.

Suggested Review Areas

- Review active treatment-reporting rows and add dates where PC implementation has been reported.
- Confirm that medicine selections are completed for T1 and the relevant T3 rounds.
- Check whether COUNTRY_INFO, SUMMARY, or DISTRICT formulas were manually edited and restore template formulas if needed.

Next step:

Would you like me to compare this submission to baseline data?

👍 👎

yes

Send

Step-by-Step Walkthrough: Step 4

Download file

The tool runs the final step with the following outputs:

1. An executive summary
2. A downloadable file with the computation outcome

3. **SCH endemicity/status changes** — 131 rows differ from corresponding-year JRSM, and 155 rows differ from latest prior JRSM.

These are high-impact because endemicity shifts can change PC requirements and treatment expectations.

Review COUNTRY_INFO SCH endemicity findings before finalizing program status.

4. **PC-required population differences** — large STH/SCH PC-required differences across many rows, plus LF differences on 9 rows.

These affect reported populations requiring preventive chemotherapy and may be downstream of population/endemicity changes.

Review COUNTRY_INFO PC-required sections after confirming population and endemicity values.

5. **Reporting completeness and formula preservation issues** — MDA1/MDA3/MDA4 dates are blank for 164 active rows; T1/T2/T3 date and medicine-selector issues are also present, and several governed formulas differ or are missing.

Missing dates/medicines and altered formulas can affect workbook readiness even if IU matching is complete.

Review MDA_REPORTING and formula findings for COUNTRY_INFO, SUMMARY, and DISTRICT.

Suggested review order

1. Source availability, 2. COUNTRY_INFO demography, 3. SCH endemicity/status, 4. PC-required populations and LF rounds, 5. MDA/T reporting dates, medicine selectors, and formula checks.



📄 jap_compute_review.xlsx

Download this



Type your message...

Send

Step-by-Step Walkthrough: Step 5

Open the workbook

Open the file generated by the tool. You will notice similarities with the original submission along with some new columns and sheets.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Administration			Population											
2	Country	Province/State	District	Total (current)	Total (latest_prior_jrsm 2024)	Total (delta %)	PreSAC (current)	PreSAC (latest_prior_jrsm 2024)	PreSAC (delta %)	SAC (current)	SAC (latest_prior_jrsm 2024)	SAC (delta %)	Adults (current)	Adults (latest_prior_jrsm 2024)	Adults (delta %)
	Angola	BENGO	AMBRIZ	35,343	32,236	9.6%	5,655	4,397	28.6%	9,861	8,974	9.9%	18,626	17,672	5.4%
	Angola	BENGO	BULA ATUMBA	20,937	19,097	9.6%	3,350	2,605	28.6%	5,841	5,317	9.9%	11,034	10,469	5.4%
	Angola	BENGO	DANDE	346,276	315,846	9.6%	55,404	43,081	28.6%	96,611	87,932	9.9%	182,487	173,147	5.4%
	Angola	BENGO	DEMBOS	46,773	42,662	9.6%	7,484	5,819	28.6%	13,050	11,877	9.9%	24,649	23,387	5.4%
	Angola	BENGO	NAMBUANGON	94,738	86,415	9.6%	15,158	11,787	28.6%	26,432	24,058	9.9%	49,927	47,373	5.4%
	Angola	BENGO	PANGO ALUQU	10,901	9,943	9.6%	1,744	1,356	28.6%	3,041	2,768	9.9%	5,745	5,451	5.4%
	Angola	BENGUELA	BAIA FARTA	149,752	136,593	9.6%	23,960	18,631	28.6%	41,781	38,027	9.9%	78,919	74,880	5.4%
	Angola	BENGUELA	BALOMBO	151,312	138,017	9.6%	24,210	18,825	28.6%	42,216	38,424	9.9%	79,741	75,661	5.4%
◀ ▶		PROFILE SUMMARY	COUNTRY INFO	IU_MATCH	DEMOGRAPHICS	ENDEMICITY	PC_REQUIRED	TREATMENT_ROUNDS	MDA_REPORTING	FORMULA_CHECKS	+				

Step-by-Step Walkthrough: Step 5

Review current values and comparisons

In COUNTRY_INFO, each field shows the current JRF value, comparison value, and change or status. Review Population, Endemicity, Population requiring PC, and Treatment rounds. Highlighted or outlined cells require attention; supporting findings appear in the corresponding detail tabs.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Administration			Population											
2	Country	Province/State	District	Total (current)	Total (latest_prior_jrsm 2024)	Total (delta %)	PreSAC (current)	PreSAC (latest_prior_jrsm 2024)	PreSAC (delta %)	SAC (current)	SAC (latest_prior_jrsm 2024)	SAC (delta %)	Adults (current)	Adults (latest_prior_jrsm 2024)	Adults (delta %)
3	Angola	BENGO	AMBRIZ	35,343	32,236	9.6%	5,655	4,397	28.6%	9,861	8,974	9.9%	18,626	17,672	5.4%
4	Angola	BENGO	BULA ATUMBA	20,937	19,097	9.6%	3,350	2,605	28.6%	5,841	5,317	9.9%	11,034	10,469	5.4%
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7	Angola	BENGO	NAMBUANGON	94,738	86,415	9.6%	15,158	11,787	28.6%	26,432	24,058	9.9%	49,927	47,373	5.4%
8	Angola	BENGO	PANGO ALUQU	10,901	9,943	9.6%	1,744	1,356	28.6%	3,041	2,768	9.9%	5,745	5,451	5.4%
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	Angola	BENGUELA	BALOMBO	151,312	138,017	9.6%	24,210	18,825	28.6%	42,216	38,424	9.9%	79,741	75,661	5.4%
◀ ▶ PROFILE SUMMARY COUNTRY_INFO IU_MATCH DEMOGRAPHICS ENDEMICITY PC_REQUIRED TREATMENT_ROUNDS MDA_REPORTING FORMULA_CHECKS +															

Step-by-Step Walkthrough: Step 5

Filter and trace review findings

Reading the file:

- Filter **has_findings = TRUE** to show rows needing review
- The **has_..._finding** columns identify type of issue.
- **source_row** and **source_cell_range** locate the original JRF cells
- **has_iu_match_finding = FALSE** means IU match is clear.

A	B	C		BU	BV	BW	BX	BY	BZ	CA	CB	CC	CD	CE	CF	CG
Administration				PC Implemented			Workbook IU Identifiers			Traceability						
Country	Province/State	District	(status)	Round 1	Round 2	Round 3	Workbook IU ID	Workbook IU name	has_findings	has_iu_match_finding	has_demographic_finding	has_endemicity_finding	has_pc_required_finding	has_treatment_round_finding	has_mda_reportin_g_finding	has_formula_check_finding
Angola	BENGO	AMBRIZ	ng	T2 (PZQ)			2049	AMBRIZ	TRUE	FALSE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
Angola	BENGO	BULA ATUMBA	ng	T3 (ALB/MBD)			2088	BULA ATUMBA	TRUE	FALSE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
Angola	BENGO	DANDE	ng	T2 (PZQ)			2050	DANDE	TRUE	FALSE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
Angola	BENGO	DEMBOS	ng	T3 (ALB/MBD)			2089	DEMBOS	TRUE	FALSE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
Angola	BENGO	NAMBUANGONGO	ng	T1 (PZQ+ALB/MBD)	T2 (PZQ)		2053	NAMBUANGONGO	TRUE	FALSE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
Angola	BENGO	PANGO ALUQUEM	ng	T1 (PZQ+ALB/MBD)	T3 (ALB/MBD)		2096	PANGO ALUQUEM	TRUE	FALSE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
Angola	BENGUELA	BAIA FARTA	ng	T2 (PZQ)			2054	BAIA FARTA	TRUE	FALSE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
Angola	BENGUELA	BALOMBO	ng	T2 (PZQ)			2055	BALOMBO	TRUE	FALSE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
PROFILE SUMMARY			COUNTRY INFO	IU MATCH	DEMOGRAPHICS	ENDEMICITY	PC_REQUIRED	TREATMENT_ROUNDS	MDA_REPORTING		FORMULA_CHECKS		+			

Next Steps

1. Explore the JRF workflow using your own submissions!
2. Provide feedback for areas such as:
 - a. Interaction steps
 - b. Output file
 - c. Understanding the chatbot message

Please fill this [Google survey form](#) after your testing!

Thank You

•THANK
•YOU



DFPC

Health Promotion,
Disease Prevention and
Control Cluster



ESPE

EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING

NTD Data Use, Reporting and Supply Chain Capacity

Online submission of JAP files

The JAP upload tool

Kintélé, Brazzaville,
Republic of the Congo



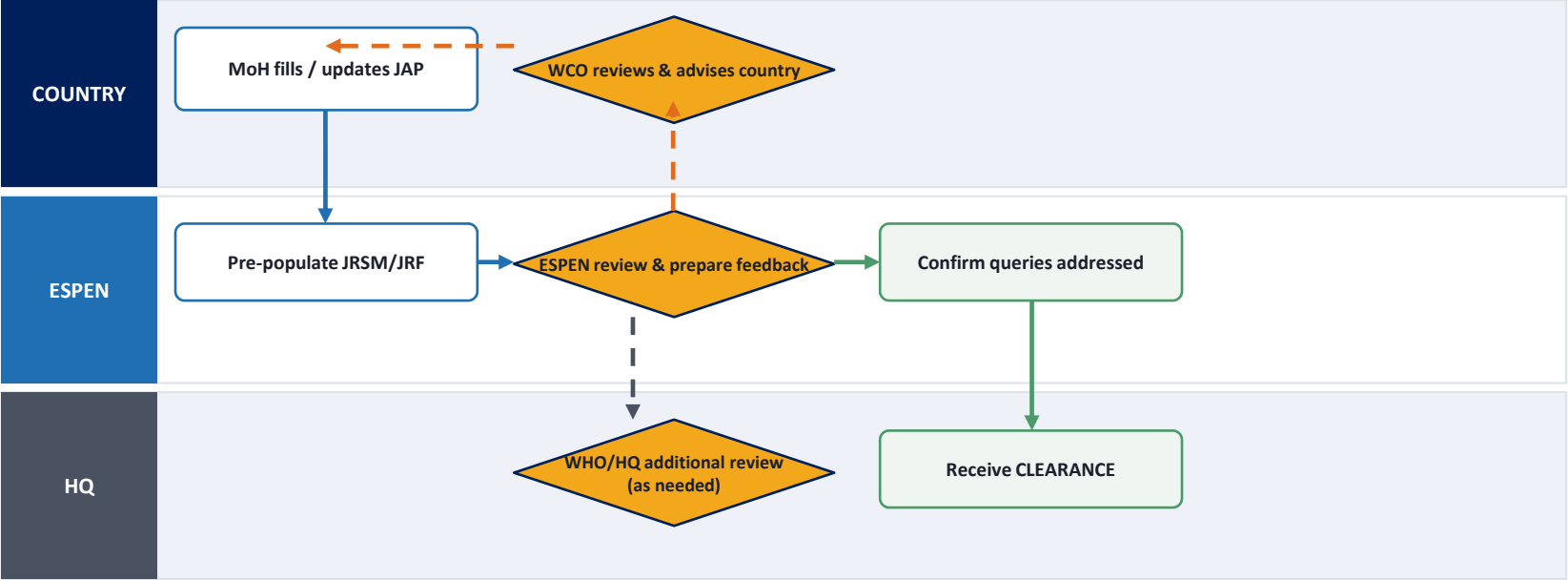
Training Workshop on Effective PC-NTD Data Processing

NTD Data Use, Reporting and Supply Chain Capacity

Online submission of data files by countries on the ESPEN Portal — The JAP Upload Tool

WHY A DEDICATED TOOL

JAP submission and review process



RISK

- X Emails get missed, lost, or buried
- X Attachments overwritten with no history
- X Vulnerable to spam / phishing
- X No shared visibility across WCO, ESPEN and HQ
- X No single source of truth for status

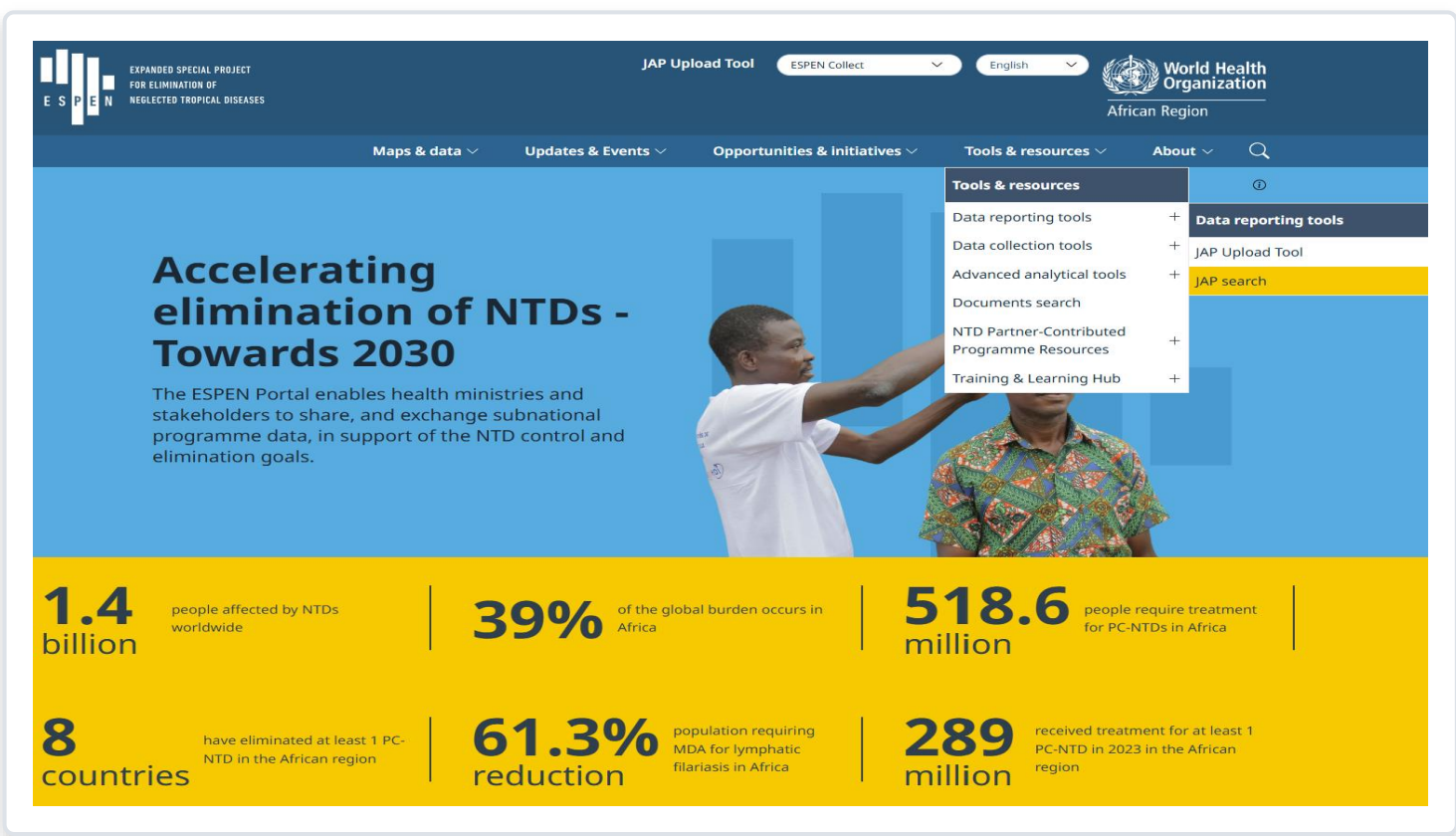
MITIGATING MEASURE

The JAP Upload Tool

One shared, trackable record for every submission.

All communications currently done through email.
The upload tool aims to make the submission, review and approval process transparent and better monitored.

Where do I access the JAP upload tool?



1

Manage & submit files

Authorized users only

2

Monitor submission & review

Publicly available

MAIN FUNCTIONS

- ▶ Submit & manage files
- ▶ Communicate
- ▶ Monitoring submission & review
- ▶ Transparency



The Joint Application Package (JAP)

A single package of 4 standardized Excel forms used by countries to request PC medicines and report programme data to WHO/ESPEN.

JRSM	JRF	EPIRF	AW
Joint Request for Selected PC Medicines Countries request the PC medicines they need for the year.	PC Joint Reporting Form Reports treatment coverage results from the MDA rounds implemented.	PC Epidemiological Data Reporting Form Captures mapping, survey and impact-assessment results.	Annual Work Plan Sets the country's objectives, activities and resource needs for the year.

Format: Microsoft Excel · Submitted through the ESPEN Portal / JAP upload tool

JAP cycles at a glance

Each annual cycle bundles the four forms together — some referencing the current year, others the most recently completed cycle.



JAP 2027

- JRSM 2027
- AW 2027
- JRF 2025
- EPIRF



JAP 2028

- JRSM 2028
- AW 2028
- JRF 2026
- EPIRF

Private interface: managing submissions

Authorized country and ESPEN users see every JAP by year, with live JRSM / JRF status and one-click access to upload or download.

API PLATFORM

Hello, Honorat Zouré

EPIRF AUTOMATION

ADMIN ▾

LOG OUT

Current JAPs

Start New JAP

Show Countries That Have

Please Select ▾

LIBE

Country

Search

Year

Search JRSM Status

JRSM Status

Search JRF Status

JRF Status

Search Last Comment

Last Comment

Liberia	2027	Approved	Under ESPEN Review		JAP Upload	Download
Liberia	2026	Approved	Approved	Dear Mr Anthony I hope thi...	JAP Upload	Download
Liberia	2025	Approved	Approved	Dear NTD Program, I hope ...	JAP Upload	Download
Liberia	2024	Approved	Approved	2	JAP Upload	Download
Liberia	2023	Approved	Approved		JAP Upload	Download
Liberia	2022	None	Approved		JAP Upload	Download
Liberia	2021	Approved	Approved		JAP Upload	Download
Liberia	2020	Approved	Approved		JAP Upload	Download
Liberia	2019	Approved	Approved		JAP Upload	Download
Liberia	2018	Approved	Approved		JAP Upload	Download

Available statuses

Every JAP file carries one of six statuses, so anyone with access can see exactly where a submission stands.

**Uploaded and Not Submitted by Country**

Draft saved but not yet sent for review.

**Uploaded on behalf of the Country**

ESPEN has pre-populated or uploaded on the country's behalf.

**Re-Submitted by MoH**

Country has revised and resubmitted the file.

**Under ESPEN Review**

ESPEN is currently reviewing the submission.

**Returned to WCO**

Sent back with feedback for revision.

**Approved**

Cleared and finalized — downloadable in the public interface.

Review and communication

Every JAP file has a running conversation thread and a notification trail — no more digging through email inboxes.

Supporting documents & comments

Documents

- [JRF_2020_Gabon_v3L_ESPEN_prepopulated.docx](#)
- [Note_importante_sur_la_soumission_en_ligne_des_fichiers_02Mars2021.docx](#)

[Add Document](#)

Add a comment:

Upload attachment

[Choisir un fichier](#) Aucun fichier n'a été sélectionné

[Add Comment](#)

NB: Le JRSM soumis ce jour 19.11.2021 tiens compte des modifications du nom de la molécule des médicaments pour les PrêSACs (Mébendazole).

Mme MOUIHHISSI Jeanne ep NDJOUNDOU 08:59 on Nov 19, 2021

Inventaire des Médicaments Pour le Praziquantel et Mébendazole.

[Download Attachment](#)

Mme MOUIHHISSI Jeanne ep NDJOUNDOU 15:06 on Nov 11, 2021

La réponse au feedback du 10.11.2021 pour le compte du JRSM 2022.

[Download Attachment](#)

Mme MOUIHHISSI Jeanne ep NDJOUNDOU 15:03 on Nov 11, 2021

Any update triggers a notification

[EXT] New 2022 JRSM_SIGNATURE uploaded for Gabon



ESPEN Portal <noreply@standardco.de>

To ○ ZOURE, Honorat Gustave Marie

[Reply](#)

[Reply All](#)

[Forward](#)



Fri 12/3/2021 2:34 PM

[If there are problems with how this message is displayed, click here to view it in a web browser.](#)

Hello,

A new 2022 JRSM_SIGNATURE was uploaded for Gabon. Click the button below to view the JAP on the ESPEN Portal.

[View JAP](#)

Keeping records of every version

All versions of a submitted file are archived — nothing is overwritten, and the full history stays downloadable.

API PLATFORM

Hello, Honorat Zouré

EPIRF AUTOMATION

ADMIN ▾

LOG OUT

Liberia 2027

JRF History

Document Name	Status	Action	User	Date Created	
Liberia_JRF2025_v44_en_reviewed_20May2026_2025_08262026_1787707215.xlsm		upload jrf	Honorat Zouré	Aug 26, 2026	Download
Liberia_JRF2025_v44_en_reviewed_20May2026_2025_05202026_1779266224.xlsm		upload jrf	Honorat Zouré	May 20, 2026	Download
FINAL_Version_Prepopulated_JRF2025_Liberia_v44_en_May_19__2026_2025_05202026_1779254917.xlsm		upload jrf	Honorat Zouré	May 20, 2026	Download
Prepopulated_JRF2025_Liberia_v44_en_2025_01262026_1769412651.xlsm		upload jrf	Honorat Zouré	Jan 26, 2026	Download

Every upload — pre-populated, revised, or re-submitted — is timestamped, attributed to a user, and stays downloadable.

Public interface: monitor and download approved files

Anyone can filter by country, year, form type and status to track progress across the region.

Country:

All

Year:

2026

Type:

All

Status:

All

Showing 1 to 25 of 60 entries (filtered from 1,084 total entries)

Show

25

Country	Year	Type	Status	Updated	Download
Angola	2026	JRSM	Approved	06 Jul 2026	Download
Benin	2026	JRSM	Approved	23 May 2025	Download
Botswana	2026	JRSM	Approved	27 Jun 2025	Download
Burkina Faso	2026	AWP	Under ESPEN Review	02 Apr 2025	
Burkina Faso	2026	EPIRF	Under ESPEN Review	24 Jul 2026	
Burkina Faso	2026	EPIRF	Under ESPEN Review	24 Jul 2026	
Burkina Faso	2026	EPIRF	Under ESPEN Review	17 Aug 2026	
Burkina Faso	2026	EPIRF	Under ESPEN Review	19 Aug 2026	
Burkina Faso	2026	JRSM	Approved	14 Oct 2025	Download
Burundi	2026	JRSM	Approved	26 Nov 2025	Download
Cameroon	2026	JRSM	Approved	15 Oct 2025	Download
Central African Republic	2026	JRSM	Approved	10 Sep 2025	Download
Chad	2026	JRSM	Approved	01 Jun 2026	Download

Only approved files are downloadable

1,084
total submissions tracked across the region, filterable by country, year, and form type.

How does a country get access?

1

Share a filled registration form

The WCO/NTD focal person shares with ESPEN a completed registration form.

2

Account created & invitation sent

An account is created, and an invitation message is sent to the country user.

3

Accept the invitation

The country user accepts the invitation to activate their access.

Registration form

List of Persons authorized to submit online JAP files on behalf of the Ministry of Health and/or Monitor Progress in the review								
Select Country								
N°	Country	Title (Dr/Mrs /Mr/Ms)	Surname	First name	Email address	Institution (MoH, WHO, NGO, ...)	Function of the person in his institution (Data Manager/M&E Officer/NTD Programme Manager, Supply Chain Officer, LF, Disease Focal person, ... etc.)	Privileges (Enter "1" to give permission)
1								Can upload files on behalf of the Ministry of Health and receive warning messages when a file is submitted
2								Can ONLY receive warning messages when a file is submitted, but CANNOT upload files
3								
4								
5								
6								

LIVE DEMO

URL

<https://espenadminweb-staging.azurewebsites.net/>

Username sc

Password b8e72787

THANK YOU

Questions & discussion





TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING
NTD Data Use, Reporting and Supply Chain
Capacity

Kintélé, Brazzaville,
Republic of the Congo

DAY 4



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES

Digital GNARF submission training

A practical guide for national NTD programmes to report complete, validated data through the Global NTD Annual Reporting Form

Presented by: Dr Sarah Kada

WHO Regional Office For Africa

Tropical Vector-Borne Diseases

Key message

Every country must submit complete, validated GNARF data every year through WIDP — on time, in scope, and reviewed at each level before it reaches WHO headquarters.

This training gives national NTD focal points everything needed to do that: the "why" behind Digital GNARF, and the "how" of logging in, entering data, validating it, and submitting with confidence.

Why GNARF? From mandate to country action

Cross-cutting target for 2030: country ownership



90%

Share of countries reporting on all relevant endemic neglected tropical diseases

90%

Share of countries collecting and reporting data on neglected tropical diseases disaggregated by gender



WHY

73rd World Health Assembly mandate: countries requested a platform to track the NTD Road Map 2021-2030

One digital system replaces fragmented Excel files, cutting errors and duplication

Timely, quality data is the only way WHO and countries can see real progress against 2030 targets

21 diseases and disease groups in one standardized form

90% of 218 countries, areas and organisation units expected to report

Governance flow: MOH → WCO → RO → HQ, reviewed at each step

Built on WIDP / DHIS2 with real-time validation

Replaces the old Excel-based annual submission entirely

GNARF: where are we?

21

neglected tropical diseases
and disease groups reported
on

218

countries, areas and
organisation units expected to
report

2021

the year Digital GNARF
reporting began

26

countries in the African region
that had already reported for
2024 as of this training

GNARF training roadmap: six modules

1

Module 1 — Strategic & Governance Foundation

Why Digital GNARF exists, the workflow, roles and coordination

2

Module 2 — System Overview

What the platform does and what is changing

3

Module 3 — Navigating Digital GNARF

Home page, metadata, validation messages, audit trail

4

Module 4 — Data Entry & Submission

Completing the form and submitting for approval

5

Module 5 — Data Quality: Spot the Error

First login, two-factor authentication, troubleshooting

6

Module 6 — Access & Logging in to WIDP

The seven most common data quality issues, and how to avoid them

Training objectives: what you will be able to do



Know

Explain the purpose, scope and governance of Digital GNARF, and how it supports the NTD Road Map 2030.



Do

Log in with 2FA, navigate the Data Entry module, enter data accurately, and resolve validation messages.



Own

Confirm your role, coordinate internally, and submit within the agreed regional reporting timeline.

MODULE 1

Strategic & Governance Foundation

From fragmented reporting to unified digital governance

What is digital GNARF?



WHO's standardized annual reporting form

Covers all 21 neglected tropical diseases and disease groups in one form.



Programmatic, epidemiological and cross-cutting data

Collects implementation data alongside Road Map indicators — not just case counts.



Hosted in WIDP, built on DHIS2

The WHO Integrated Data Platform gives every country a single, secure system of record.



Enables monitoring of the NTD Road Map 2021–2030

Compliant with the World Health Assembly request from Member States.

Changes in the GNARF? From excel to digital GNARF

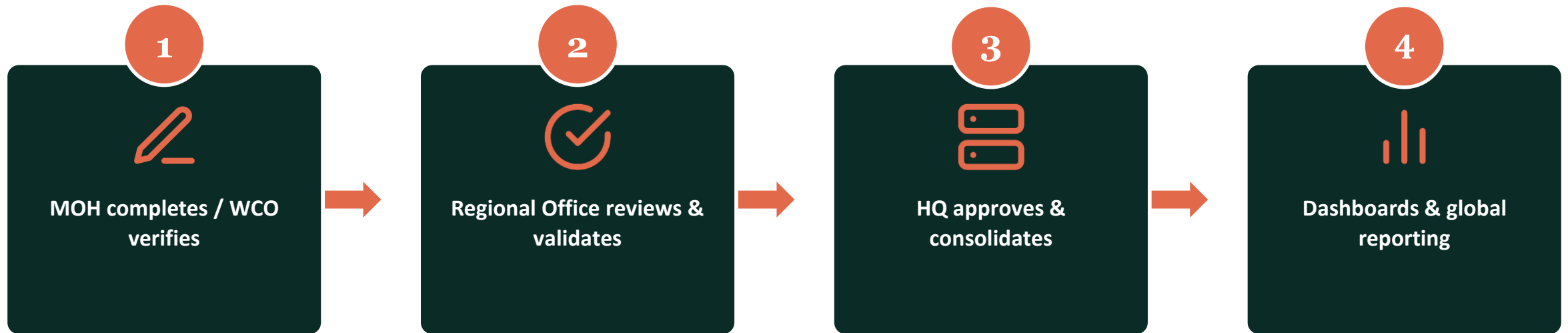
Before: Excel GNARF

- Multiple excel file versions due to corrections
- Separate files by disease
- Manual validation and cross-checking
- Duplicate data-entry across platforms
- Limited version control

Now: Digital GNARF

- Single centralized platform within WIDP
- All diseases reported in one system
- Real-time automated validation rules
- No duplication across modules
- Multiple authorized users, same time
- Full audit trail and version history

Reporting workflow: governance in action



Data is entered once at national level and reviewed progressively through structured validation layers.

Roles and accountability: who does what?

Level	Role	Core Responsibility
National (MOH)	Disease Focal Points	Enter programmatic and epidemiological data; resolve validation errors
National (MOH)	Programme Manager	Coordinate and oversee national submission; internal review before submission
WHO Country Office	Verification	Review completeness and consistency; confirm submission readiness
Regional Office (AFRO)	Validation	Conduct regional technical review; validate prior to HQ review
HQ	Disease Focal Points	Review disease-specific trends and anomalies; flag technical inconsistencies to RO
HQ	GNARF Data Management Team	Manage metadata, validation rules, and global harmonized dataset

Organisation at country level



Identify your national focal point(s)

Confirm who enters data for each disease and who has final sign-off.



Ensure WIDP access & 2FA are active

Every contributor needs a working login before the reporting window opens.



Coordinate internally before submission

Cross-check disease-specific inputs so the WCO can verify a consistent dataset.

SUBMISSION DEADLINES

2024 data

30 April 2026

2025 data

31 May 2026

Multi-level review takes place before final HQ approval — build this time into your internal plan.

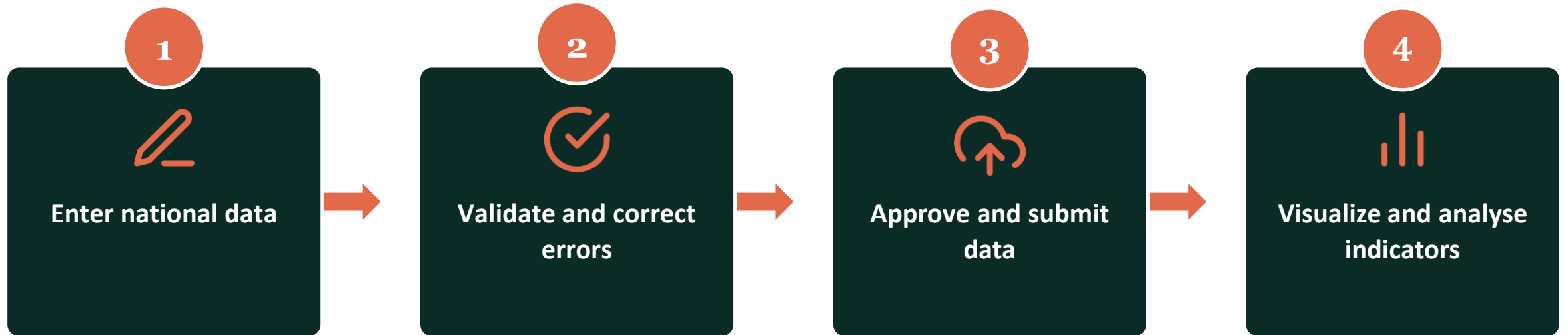
MODULE 2

System Overview

What the Digital GNARF platform does, end to end



How does GNARF works?



Accessed through the WHO Integrated Data Platform (WIDP) — a single space for every reporting country.

Digital GNARF: major system enhancements



Improved navigation and centralized dashboard

A clearer home page brings every module into one view.



Real-time validation with consistency checks

Errors are caught as you type, not after submission.



Multiple users can access simultaneously

Country teams no longer bottleneck on a single Excel file.



Integrated metadata dictionary and embedded guidance

Definitions and instructions live inside the form itself.



Enhanced readability and clearer interface

Streamlined data entry with flexible disaggregation.



Full audit trail and strengthened accountability

Every change is logged, timestamped and attributable.

Digital GNARF: upcoming system enhancements

PHASE 2 — AVAILABLE NOW

- Internal performance dashboard for countries
- Offline version and ability to upload
- Dedicated data quality application module and complete data validation rules
- Structured data approval workflow process

PHASE 3 — PLANNED

- Multilingual interface and translation support (English, French, Spanish, Portuguese)
- Progressive transition of historical NTD datasets into GNARF (legacy forms, GNARF 2023–2024, regional database)
- Integration into the NTD Roadmap tracker and Country Profiles

MODULE 3

Navigating Digital GNARF

Home page, metadata, validation and the audit trail



Digital GNARF: home page layout



Data Entry



Bulk Load



Data Approval



Data Quality



Data Visualization



Browser Cookie Cleaner



Metadata Dictionary



Data Sharing Policy

Metadata Dictionary & Embedded Guidance

- 1 Every field links to a metadata dictionary entry.
- 2 Definitions, units and calculation rules are shown in context.
- 3 Guidance text appears directly next to ambiguous fields.
- 4 Use the dictionary before asking AFRO or HQ contact — most answers are already there.

Metadata Dictionary

Run automated data checks and validation reports to ensure completeness and accuracy.

Data Sets

Number of Data Sets: 72

NTD GNARF

Table of Content

- Sections
 - Buruli ulcer
 - Buruli ulcer: additional information
 - Buruli ulcer: classification of new cases by clinical presentation
 - Buruli ulcer: health status and service coverage
 - Buruli ulcer: health system
 - Buruli ulcer: medicine and stock
 - Chagas disease
 - Chagas disease: additional information
 - Chagas disease: coverage of vector control interventions in d
 - Chagas disease: health status and service coverage by age g
 - Chagas disease: health system
 - Chagas disease: household infestation and colonisation by tr
 - Chagas disease: testing for T. cruzi among pregnant women
 - Chagas disease: transfusion and transplantation safety
 - Chagas disease: treatment coverage by treatment group
 - Chikungunya
 - Chikungunya: additional information
 - Chikungunya: health status by age group and sex
 - Chromoblastomycosis and other deep mycoses: Chromoblast
 - Chromoblastomycosis: additional information
 - Chromoblastomycosis: health status and service coverage by
 - Chromoblastomycosis: health system
 - Common skin diseases
 - Common skin diseases: additional information
 - Common skin diseases: Are the following medicines listed on
 - Common skin diseases: health status by age group and sex
 - Contact
 - Country progress
 - Leishmaniasis (cutaneous)
 - Cutaneous leishmaniasis: Active detections
 - Cutaneous leishmaniasis: additional information
 - Cutaneous leishmaniasis: Antileishmanial medicines included
 - Cutaneous leishmaniasis: by origin (imported cases)
 - Cutaneous leishmaniasis: clinical presentation - cases by size
 - Cutaneous leishmaniasis: Control activities

Clinical description

Dengue is an acute viral infection transmitted by Aedes mosquitoes. A suspected dengue case is a person who lives in or has travelled to an area with dengue transmission within the previous 14 days and presents with acute fever (usually lasting 2-7 days) and at least two of the following: nausea or vomiting, myalgia, headache, joint pain, skin rash, or other organ failure.

Dengue with warning signs refers to dengue cases presenting near or at defervescence, or shortly thereafter, with one or more of the following: severe abdominal pain or tenderness, persistent vomiting, clinical fluid accumulation (ascites, pleural or pericardial effusion), mucosal bleeding, lethargy or restlessness.

Severe dengue is characterized by severe plasma leakage leading to shock or respiratory distress, severe bleeding as evaluated by the clinician, or severe organ involvement such as liver failure (AST or ALT >1000 IU), central nervous system involvement, myocarditis, or other organ failure.

Case classification	Definition
Suspected case	A case compatible with the clinical description of dengue.
Probable case	A suspected dengue case with a positive IgM or NS1 test result, or with a clinical-epidemiological link to a confirmed dengue case or outbreak. Note: During outbreaks, suspected cases that cannot be fully investigated may be reported as probable cases.
Confirmed case	Every laboratory-confirmed dengue case using one or more of the following methods: - Conventional or real-time RT-PCR, or other validated molecular assays - Viral isolation - IgM or IgG seroconversion in paired serum samples - Four-fold increase in IgG antibody titre in paired sera Note: Laboratory diagnosis should include differential diagnosis for other diseases according to national epidemiological contexts. Serological testing should consider cross-reactivity with other flaviviruses.
Death from dengue	Any patient meeting the definition of a suspected, probable, or confirmed dengue case who dies as a consequence of dengue. Note: Laboratory confirmation is recommended for all dengue-related deaths, and deaths should be reviewed by an interdisciplinary committee.

Indicator definitions

Indicator	Definition
Number of new suspected cases	Suspected dengue cases first reported during the calendar year, disaggregated by age group and sex.
Number of new probable cases	Probable dengue cases first reported during the calendar year, disaggregated by age group and sex.
Number of new confirmed cases	Confirmed dengue cases first reported during the calendar year, disaggregated by age group and sex.
Number of dengue deaths	Deaths in which dengue was determined to be the primary underlying cause of death, disaggregated by age group and sex.

Reporting rules

Dengue cases should be classified as suspected, probable, or confirmed according to WHO case definitions. Suspected, probable, and confirmed cases are mutually exclusive. Each case should be reported once, using the highest level of classification achieved. Total dengue cases should equal the sum of new suspected, new probable, and new confirmed cases for the same reporting period. Age group and sex disaggregation should sum to the corresponding all-ages totals for each indicator. Deaths may be reported even when no new dengue cases are reported during the same year. "New" denotes cases first reported during the calendar year. Blank fields indicate that no data are available.

References

World Health Organization. Routine health information system and health facility data for neglected tropical diseases: general guidance for national programme managers and data clerks. Geneva: World Health Organization; 2026.

Real-Time Validation Messages: catch errors early



Messages appear as you type

No need to wait for a final submission check — issues surface immediately.



Resolve or comment before moving on

Use the comment icon to explain outliers your reviewer should expect.



Each message explains the rule triggered

Consistency checks compare values across diseases, years and indicators.



Run a full validation check before submitting

This catches anything you may have missed field by field.

Run validation

Print form

Print blank form

Validation			
Ensures that the sum of Category I, II, and III Buruli ulcer cases does not exceed the total number of confirmed BU cases.	11.0	>	21.0
verify this entry. Note: Deaths may relate to cases diagnosed in previous years.			
BUR: The total number of male lab-confirmed BU cases (all ages) does not match the sum of the detailed age groups. Please review the lab-confirmed BU cases reported for each detailed male age group and ensure that the values add up to the total for males (all ages).	3.0	==	2.0
BUR: The number of unspecified sex case tested for PCR cannot exceed the number of suspected BU unspecified sex cases, for all ages. Please review the values entered.	23.0	<=	2.0
ECH: The sum of cystic echinococcosis cases across age groups does not match the total number of new cystic echinococcosis cases. Please review the values entered.	12.0	==	3.0

Audit trail

The screenshot displays a web interface for data submission. At the top, there is a 'Comment' section with a star icon and a text area. Below it is a 'Save comment' button. To the right, the 'Min-max limits' section includes input fields for 'Min limit' and 'Max limit', and a label 'Average 8.0'. Below these are 'Save' and 'Remove' buttons. Further right, it shows 'Stored by Farah AGUA' and 'Last updated 2025-11-13'. At the bottom, there are two tabs: 'Data element history' and 'Audit trail'. The 'Audit trail' tab is active, showing a table of modifications.

On	Modified by	Value	Modification
2025-11-13 14:37	farah.agua	5	Update
2025-10-20 14:20	farah.agua	No value	Create
2025-10-16 10:05	farah.agua	3	Delete
2025-10-16 09:59	farah.agua	6	Update
2025-10-06 14:27	farah.agua	No value	Create
2025-10-06 14:27	farah.agua	7	Delete
2025-10-06 14:27	farah.agua	No value	Create

- 1 Every entry, edit and comment is logged automatically.
- 2 View who changed a value, when, and what it was before.
- 3 Use the audit trail to add comments or supporting context.
- 4 Historical submissions remain visible for year-on-year comparison.

Accountability in the system



Disease focal points identified per country

Each disease has a named responsible contact recorded in the system.



Actions are attributable

The audit trail ties every change to an individual user account.



Submission is explicit

MOH marks the report complete.

Contact

By affixing your name you verified that the information is correct. Completed and submitted by the Ministry of Health

Contact

Name of person who is authorized by the MOH to submit the report

Email address

Contact number

Official in the WHO Country Office who approved and verified the information

Diseases Focal Points

List all disease focal points with designation, if applicable

	Name	Designation	Contact details
1. Focal point			
2. Focal point			
3. Focal point			
4. Focal point			

Complete

Incomplete

Run validation

GNARF SUBMISSION TRAINING - 2026



World Health
Organization

African Region

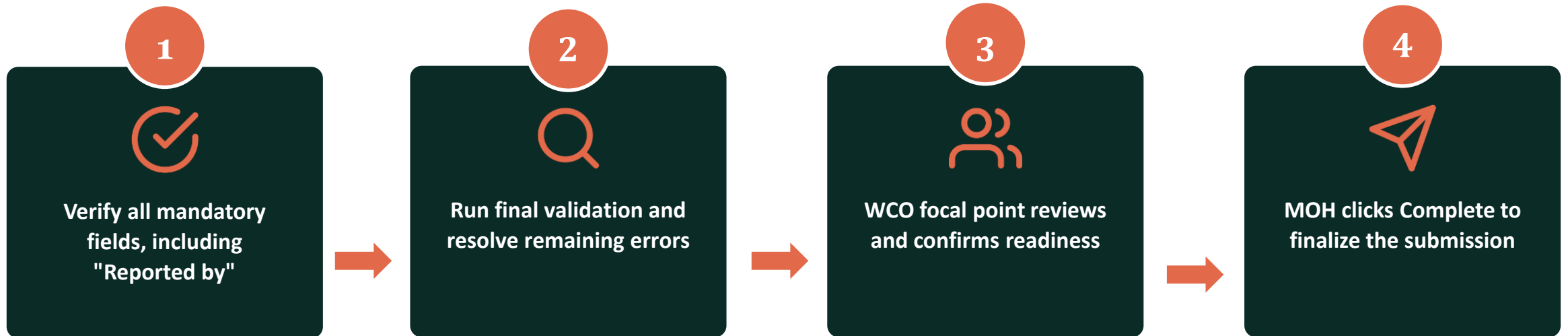
MODULE 4

Data Entry & Submission

From opening the form to final country sign-off



Submission checklist



MODULE 5

Data Quality: Spot the Error

The seven most common issues reviewers find — and how to avoid them



Common data quality issues



Not filled or Unmatched disease reporting status

Endemic one year, not reporting the next, with no explanation.



Unmatched program status between years

Adoption status (full / partial / not adopted) changes without a comment.



Absence of zero-reporting

A country with genuinely no cases must still actively report zero.



Inconsistent data

Values that contradict related indicators or prior-year trends.



Missing mandatory fields

"Reported by" and other required fields left blank at submission.



Unresolved validation messages

Warnings left unaddressed instead of explained via comment.



No supporting comment on outliers

Unusual values submitted with no context for the reviewer.

Common data quality issues

Data Entry 

Organisation Unit

Data Set

NTD GNARF

Period

2024

Prev year

Next year

INTRODUCTION

COUNTRY PROGRESS

LEPROSY

RABIES

SOIL-TRANSMITTED HELMINTHIASES

TRACHOMA

This section gathers basic information on national and NTD focal points in the country.

WHO Integrated data platform

Data Entry 

 the

Organisation Unit

Data Set

NTD GNARF

Period

2025

Prev year

Next year

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Organisation Unit

Data Set

Period

! Unmatched disease reporting status

[INTRODUCTION](#) [COUNTRY PROGRESS](#) [LEPROSY](#) [RABIES](#) [SOIL-TRANSMITTED HELMINTHIASES](#) [TRACHOMA](#)

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✕ the

Organisation Unit

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[INTRODUCTION](#) [COUNTRY PROGRESS](#) [LEPROSY](#) [RABIES](#) [SCHISTOSOMIASIS](#) [SOIL-TRANSMITTED HELMINTHIASES](#) [TRACHOMA](#)

Introduction

This section gathers basic information on national and NTD focal points in the country.

Common data quality issues

🔑 Has the country adopted and implemented (fully and partially) the WHO-recommended integrated skin NTD strategy (latest available data)

	Adopted and im...	
	2024 ▾	2025 ▾
Country 1		2
Country 2	2	2
Country 3	2	2
Country 4	2	2
Country 5	1	1
Country 6	1	1
Country 7	1	2
Country 8	2	1
Country 9	1	1
Country 10	2	2
Country 11	2	2
Country 12		2
Country 13	1	1
Country 14		1
Country 15	2	2
Country 16	2	2
Country 17		2
Country 18		

Integrated Skin NTD (5.2)

- Yes, adopted and implemented fully
1-<2
- Yes, adopted but partially implemented
2-<3
- Yes, adopted but not implemented
3-<4
- No, not adopted nor implemented
4-<5
- Not required
5-<6

Common Data Quality Issues

! Unmatched program status between years

Has the country adopted and implemented (fully and partially) the WHO-recommended integrated skin NTD strategy (latest available data)

	Adopted and im...	
	2024 ▲	2025 ▲
Country 1		2
Country 2	2	2
Country 3	2	2
Country 4	2	2
Country 5	1	1
Country 6	1	1
Country 7	1	2
Country 8	2	1
Country 9	1	1
Country 10	2	2
Country 11	2	2
Country 12		2
Country 13	1	1
Country 14		1
Country 15	2	2
Country 16	2	2
Country 17		2
Country 18		

Integrated Skin NTD (5.2)

- Yes, adopted and implemented fully
1-<2
- Yes, adopted but partially implemented
2-<3
- Yes, adopted but not implemented
3-<4
- No, not adopted nor implemented
4-<5
- Not required
5-<6

Common data quality issues

Noma: health status and service coverage by age group and sex							
	Number of suspected cases			Number of new clinically confirmed cases (Stage 1)			Number of new c
	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male
All Ages							
Age group (years)	19	17					
<1 year							
1–4 years	5	3					
5–14 years	14	14					
15–24 years							
25–49 years							

Common data quality issues

Noma: health status and service coverage by age group and sex							
	Number of suspected cases			Number of new clinically confirmed cases (Stage 1)			Number of new c
	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male
All Ages							
Age group (years)	19	17					
<1 year							
1–4 years	5	3					
5–14 years	14	14					
15–24 years							
25–49 years							

Common Data Quality Issues

Noma: health status and service coverage by age group and sex

Noma: health status and service coverage by age group and sex										
								Service coverage		
Number of cases detected during active case searches		Number of new clinically confirmed cases detected during active case searches			Number of deaths (primary cause)			Number of clinically-confirmed cases treated		
Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown
All Ages										
Age group (years)					4	3		13	8	
<1 year										
1–4 years								5	3	
5–14 years					4	3		8	8	
15–24 years										
25–49 years										

Common data quality issues

Noma: health status and service coverage by age group and sex

								Service coverage		
Cases detected during active case searches		Number of new clinically confirmed cases detected during active case searches			Number of deaths (primary cause)			Number of clinically-confirmed cases treated		
Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown
All Ages										
Age group (years)					4	3		13	8	
<1 year										
1–4 years								5	3	
5–14 years					4	3		8	8	
15–24 years										
25–49 years										

Common data quality issues

Buruli ulcer: health status and service coverage

Case Detection										
Number of clinical cases		Number of suspected cases tested by PCR			Number of new laboratory-confirmed cases by PCR			Number of suspected cases positive by PCR if PCR is not available		
Male	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown
All Ages				11	8					
Basic level age group (years)				11	8					
<5 years										
5–14 years										
15+ years				11	8					

Common data quality issues

Buruli ulcer: health status and service coverage

Case Detection										
Number of clinical cases		Number of suspected cases tested by PCR			Number of new laboratory-confirmed cases by PCR			Number of suspected cases positive by PCR if PCR is not available		
Male	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown	Male	Female	Sex unspecified or unknown
All Ages					11	8				
Basic level age group (years)					11	8				
<5 years										
5–14 years										
15+ years					11	8				

Conclusion

Wrap-Up, Q&A and next steps



Recap GNARF? What this training covered

Cross-cutting target for 2030: country ownership



Submit complete, validated GNARF data every year, on time, through WIDP



WHY

GNARF is WHO's official governance mechanism for tracking the NTD Road Map 2021-2030

The MOH → WCO → RO → HQ workflow keeps data quality high at every level

Real-time validation and the audit trail make errors visible and fixable early

Activate your WIDP login and 2FA now

Coordinate disease focal points internally

Enter and validate your data

Resolve all messages before submission

Submit before deadline

WHO support model to member states during submission period

Resources

- <https://extranet.who.int/dhis2-indiv/dhis-web-login/#/>
- [GNARF SharePoint site \(Global NTD Annual Reporting System\)](#)
- [Digital GNARF FAQ](#)
- Recorded trainings on the NTD YouTube channel: [AFRO Regional Training on Digital GNARF Implementation](#)
- [GNARF Assist \(AI agent\)](#)

Technical Support

- Online Booking system for direct technical support
- GNARF Clinics for hands-on troubleshooting
- Deep-dive training sessions on request
- GlobalNTDdata@who.int and WCO/AFRO support for all inquiries

References

- [NTD Road Map Monitoring and Evaluation Framework](#)
- [Compendium of NTD indicators](#)
- RHIS for Data Clerks and Programme Managers

Thank you for your commitment to complete, timely, and accurate GNARF reporting.

Questions

GNARF Support team:

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Lamis Ibrahim (WHO Regional office for Africa) – lamisa@who.int

Dr Junerlyn Farah (WHO HQ) – farahj@who.int

GlobalINTDdata – GlobalINTDdata@who.int



GNARF Demonstration



MODULE 6

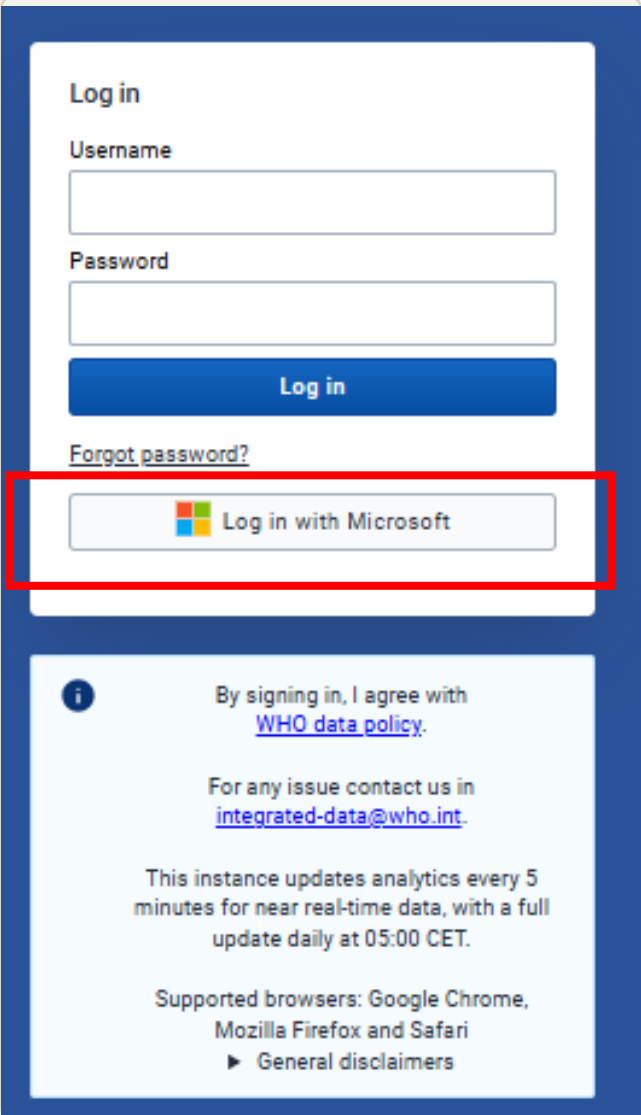
Access & Logging in to WIDP

WHO and non-WHO access, first login, and two-factor authentication



How to Log In (WHO Staff)

- 1 Access WIDP at the official WHO login URL.
<https://extranet.who.int/dhis2-indiv/dhis-web-commons/security/login.action>
- 2 Authenticate with your WHO email address and click "Log in with Microsoft". No password needed.
- 3 Accept the WHO Data Policy.
- 4 Enter the 6-digit code from your authenticator app to complete sign-in.



Log in

Username

Password

Log in

[Forgot password?](#)

 Log in with Microsoft

i By signing in, I agree with [WHO data policy](#).

For any issue contact us in integrated-data@who.int.

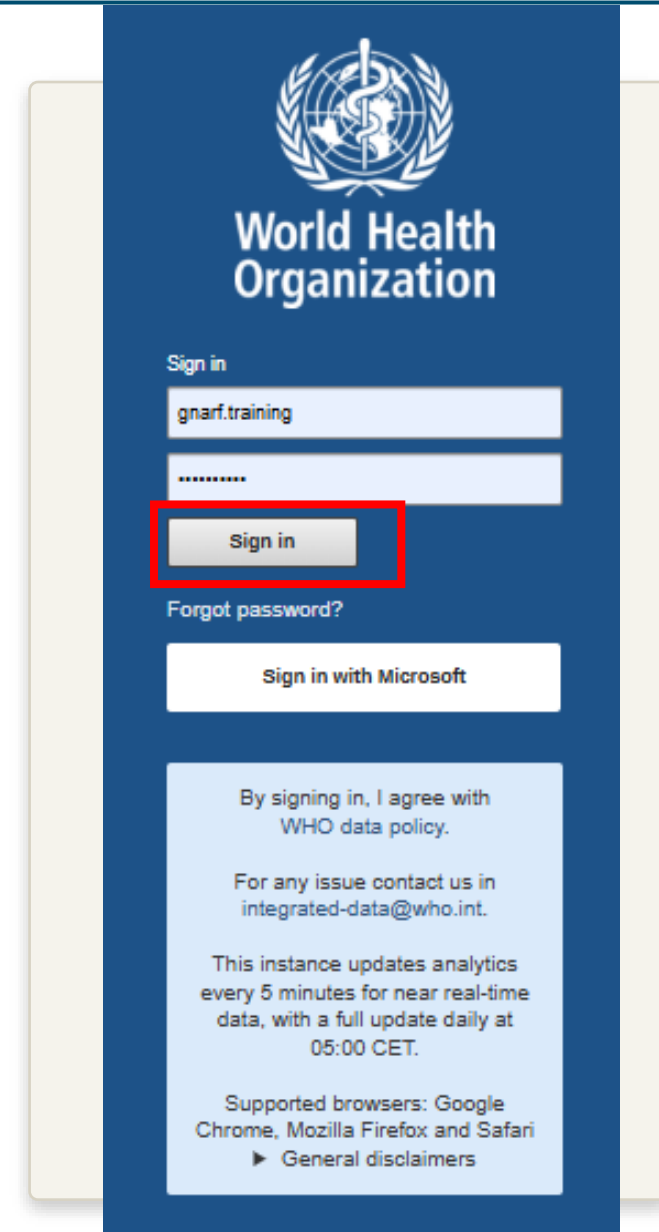
This instance updates analytics every 5 minutes for near real-time data, with a full update daily at 05:00 CET.

Supported browsers: Google Chrome, Mozilla Firefox and Safari

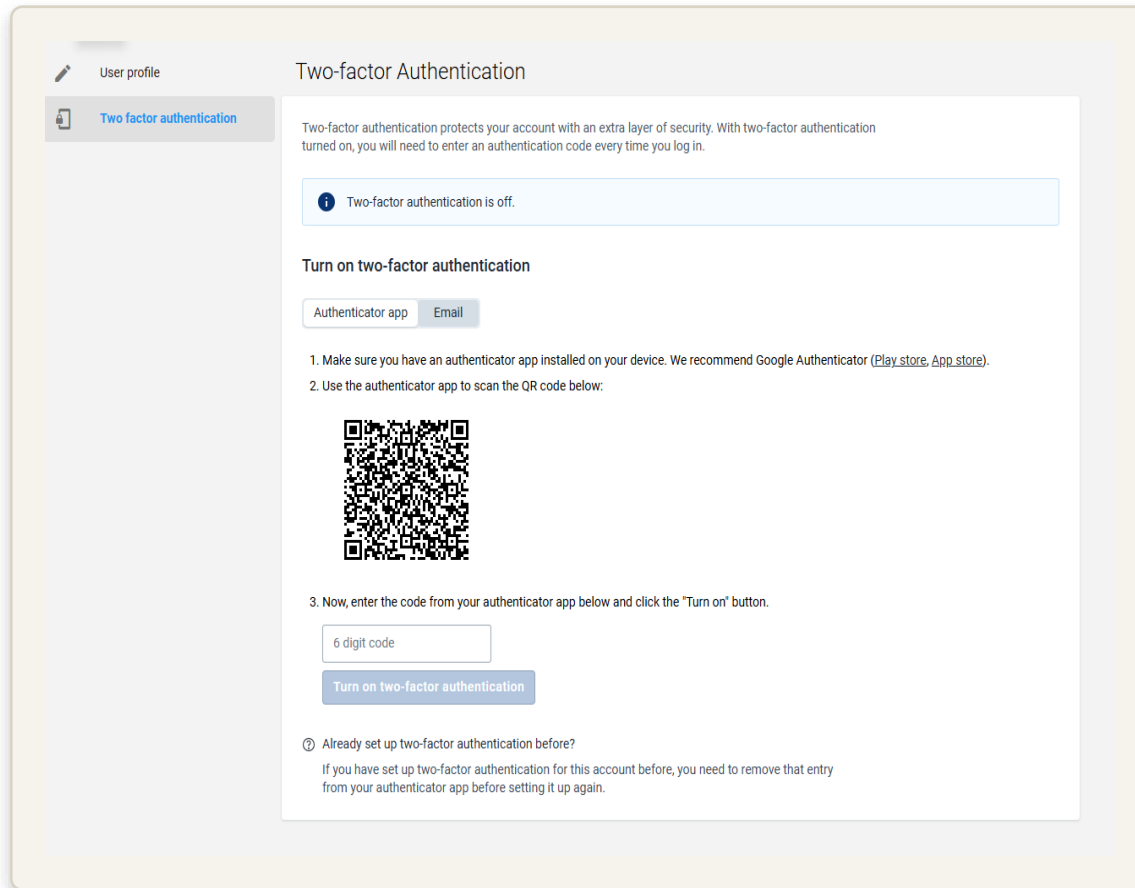
► General disclaimers

How to Log In (MOH personnel)

- 1 Access WIDP at the official WHO login URL.
<https://extranet.who.int/dhis2-indiv/dhis-web-commons/security/login.action>
- 2 Enter the temporary username and password you received.
- 3 Click "Sign in" — you agree to the WHO Data Policy by doing so.
- 4 You will be prompted to set up two-factor authentication (2FA) before continuing.

A screenshot of the World Health Organization (WHO) login page. The page has a dark blue header with the WHO logo and the text "World Health Organization". Below the header, there is a "Sign in" section with two input fields: one for the username "gnarf.training" and one for the password, which is masked with dots. A red rectangular box highlights the "Sign in" button. Below the password field, there is a link "Forgot password?". Further down, there is a white button labeled "Sign in with Microsoft". At the bottom, there is a light blue box containing text about the WHO data policy, contact information for integrated-data@who.int, update frequency (every 5 minutes), supported browsers (Google Chrome, Mozilla Firefox, and Safari), and a link to "General disclaimers".

Setting up 2FA (WHO and MOH users)



The screenshot shows a user profile settings page with a sidebar containing 'User profile' and 'Two factor authentication'. The main content area is titled 'Two-factor Authentication' and includes a status message: 'Two-factor authentication is off.' Below this, there's a section 'Turn on two-factor authentication' with two tabs: 'Authenticator app' (selected) and 'Email'. The instructions for the authenticator app are: 1. Make sure you have an authenticator app installed on your device. We recommend Google Authenticator ([Play store](#), [App store](#)). 2. Use the authenticator app to scan the QR code below: A QR code is displayed. 3. Now, enter the code from your authenticator app below and click the "Turn on" button. A text input field labeled '6 digit code' is shown, followed by a 'Turn on two-factor authentication' button. At the bottom, there's a note: 'Already set up two-factor authentication before? If you have set up two-factor authentication for this account before, you need to remove that entry from your authenticator app before setting it up again.'

- 1 From your account settings, open "Two-Factor Authentication".
- 2 Scan the QR code with an authenticator app on your phone.
- 3 Enter the 6-digit code the app generates to confirm the link.
- 4 Save your recovery details in case you change devices later.

Installing an Authenticator app

Google Authenticator

- Open the Play Store (Android) or App Store (iPhone)
- Search "Google Authenticator" and install
- Open the app and tap "+"
- Choose "Scan a QR code" and scan the WIDP code

Microsoft Authenticator

- Open the Play Store (Android) or App Store (iPhone)
- Search "Microsoft Authenticator" and install
- Open the app, tap "+", choose Personal account
- Choose "Scan a QR code" and scan the WIDP code

Common troubleshooting tips (login + 2FA)

Issue	Solution
Code expired	Try again — codes refresh every 30 seconds
Wrong time setting	Enable automatic date/time on your phone
QR code not scanning	Increase brightness / zoom screen
Authenticator entry deleted	Contact your WHO Admin to reset 2FA
Didn't receive temporary password	Check spam, or ask your WHO focal point

Access & security best practices



Do not uninstall the authenticator app

It's your only way to generate valid 2FA codes for WIDP.



Keep your browser up to date

Older browsers can break validation and form rendering.



Do not share login credentials

Each user should have their own account and audit trail.



Keep your phone charged during submission

You'll need your authenticator app throughout the process.



Log out when using shared devices

Protect national data on computers used by multiple staff.



Notify WHO support if you lose access

Early notice avoids delays close to the submission deadline.

Try it yourself: Practice session



Log in with your official credentials

From the homepage, click "Global NTD Annual Reporting Form (User View)".



Select organisation unit, dataset and period

Choose your country, "NTD GNARF", and the relevant reporting year (2024 or 2025).



Select status of reporting for the year for each disease

Look at how disease categories expand and collapse in the form.

Status of Reporting For the Year	
Buruli ulcer	Yes, country is endemic (report required)
Chagas disease	Yes, country is endemic (report required)
Chikungunya	Yes, country is not endemic but reports for surveillance/zero-reporting No, country is known to be endemic but no surveillance system exists or data are not available No, country is not endemic and will not report for this disease

GNARF submission 2024 and 2025



Developing multi-year MDA & M&E projections for LF, Onchocerciasis and STH

TRAINING WORKSHOP ON EFFECTIVE PC-NTDs DATA PROCESSING AND USE FOR ENGLISH-SPEAKING COUNTRIES

*Kintélé International Conference Centre, Brazzaville (Congo)
24 to 28 August 2026*

Presenter: Dr Jorge Cano
ESPEN Surveillance Officer



What this session covers

01	Background	Why multi-year, IU-level projections matter for programmes, supply chains and donors
02	Methodology	A single deterministic engine; shared logic plus disease-specific decision rules
03	Assumptions	Endemicity, effective-coverage thresholds and survey ladders for LF, Oncho & STH
04	Analytics	AFRO regional trajectories 2026–2035, key-country highlights and elimination timelines
05	Wrap-up	Conclusions and the next frontier: sub-IU projections for schistosomiasis

Why multi-year projections — and why they matter for supply chains

A single, harmonized and reproducible dataset of IU-level annual projections (2026–2035) turns endemicity and treatment history into forward-looking operational intelligence.

1 Medicine quantification & forecasting

Year-by-year ‘population to be targeted’ feeds donation requests (Mectizan, albendazole, DEC/IDA) and de-risks supply planning.

2 Programme planning & JRSM validation

An independent benchmark to review national submissions and validate the JRSM medicine request.

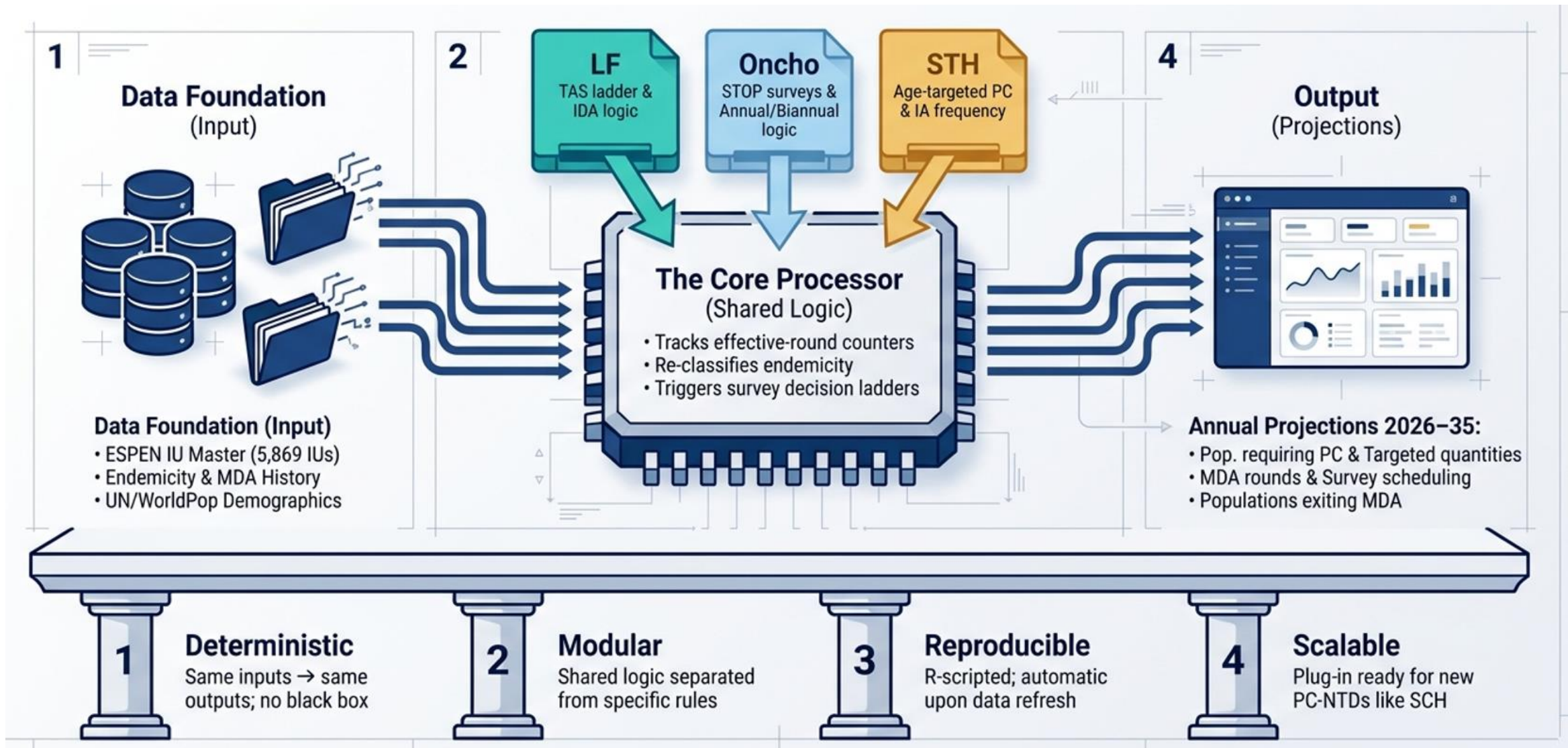
3 Survey & transition scheduling

Anticipates when IUs move from MDA to TAS / stop-MDA / impact assessment — timing of diagnostics and surveys.

4 Regional strategy & donor engagement

Consistent trajectories for regional reporting and resource mobilization, aligned to the NTD Roadmap 2030.

One engine, three diseases: a modular deterministic pipeline



One engine, three diseases: a modular deterministic pipeline

	Lymphatic Filariasis (LF)	Onchocerciasis (Oncho)	Soil-Transmitted Helminths (STH)
 Targeting & Efficacy Thresholds	Total population ≥65% epidemiological coverage required to count as an effective round.	Total population ≥80% therapeutic coverage required to count as an effective round.	Age-targeted (Pre-SAC, SAC, WRA) ≥75% coverage on School-Aged Children (SAC) required.
 Treatment Logic & Frequency	Standard IVM+ALB (Eligible IUs accelerated with IDA). Co-endemic loiasis modified to ALB 2×/yr.	Standard CDTI. Higher-transmission IUs scaled to Biannual (2×/yr) MDA to shorten EOT timelines.	Driven by baseline prevalence: ✓ ≥50% (2×/yr) ✓ 20–50% (1×/yr) ✓ <20% (Scale down frequency).
 Survey Ladder & Transition	≥5 effective rounds → Pre-TAS → TAS 1, 2, 3 → Stop MDA / Surveillance.	Pre-STOP evaluation → Full-STOP survey → Stop MDA / Surveillance.	No permanent stop. IA after 5 effective MDA rounds downgrade prevalence and PC frequency.

LF — stop-MDA pathway driven by effective treatment & TAS

PROGRAMME DECISION PATHWAY

- 1** **Endemic IU requires MDA** ivermectin + albendazole (IDA where eligible)
- 2** **Count effective rounds** each round at $\geq 65\%$ epidemiological coverage
- 3** ≥ 5 effective rounds → **Pre-TAS/EMS** eligibility assessment to enter TAS
- 4** **TAS-1 → TAS-2 → TAS-3** pass, then re-survey at ~ 2 -year intervals
- 5** **Stop MDA → post-MDA surveillance** IU exits treatment, enters surveillance

Target: Elimination as a public health problem (EPHP) by 2030

KEY ASSUMPTIONS

- MDA effective only at $\geq 65\%$ coverage; sub-threshold rounds do not count toward stop criteria
- IDA (IVM+DEC+ALB) accelerates timelines where eligible — Madagascar, Zambia, Zimbabwe
- Loiasis co-endemic IUs use albendazole-twice-yearly / test-and-treat (no ivermectin)
- Survey ladder mapped to MDA history: Pre-TAS/EMS → TAS1–3 → surveillance
- Population denominators grow with UN/WorldPop projections

Oncho — CDTI toward elimination of transmission (EOT)

PROGRAMME DECISION PATHWAY

1 **Endemic IU requires CDTI** community-directed treatment with ivermectin

2 **Set treatment frequency** annual or biannual by transmission intensity

3 **Count effective rounds** each round at $\geq 80\%$ therapeutic coverage

4 **Pre-STOP evaluation** epidemiological & entomological eligibility

5 **Full-STOP survey → Stop MDA** then ongoing post-treatment surveillance

Target: Elimination of transmission (EOT) — verification dossiers

KEY ASSUMPTIONS

- Effective treatment requires $\geq 80\%$ therapeutic coverage
- Biannual MDA assumed for higher-transmission IUs to shorten time-to-EOT
- Ongoing epidemiological/entomological monitoring (OEM) runs alongside MDA
- Stop decision needs sustained effective coverage plus survey criteria
- Co-endemicity with loiasis flagged for safety (severe-adverse-event risk)

STH — age-targeted PC with prevalence-driven frequency

PROGRAMME DECISION PATHWAY

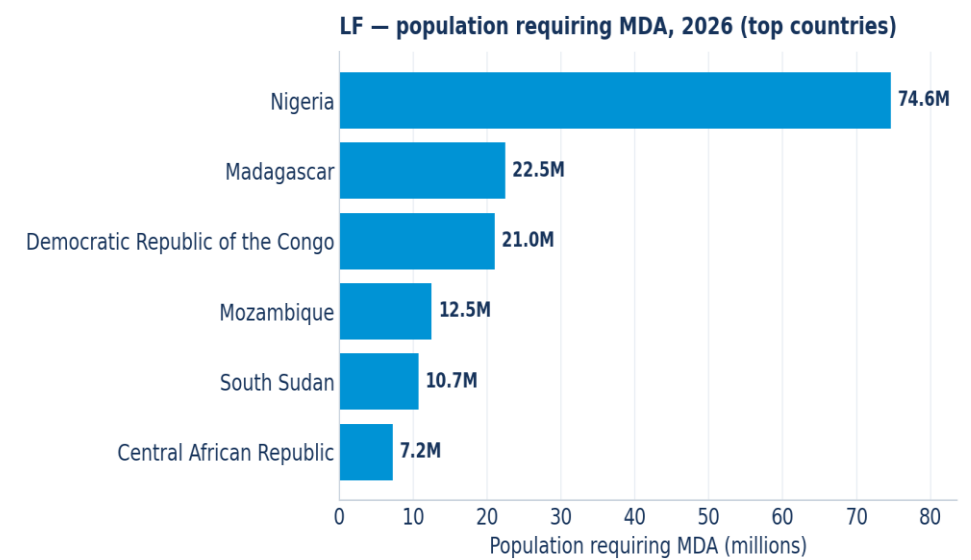
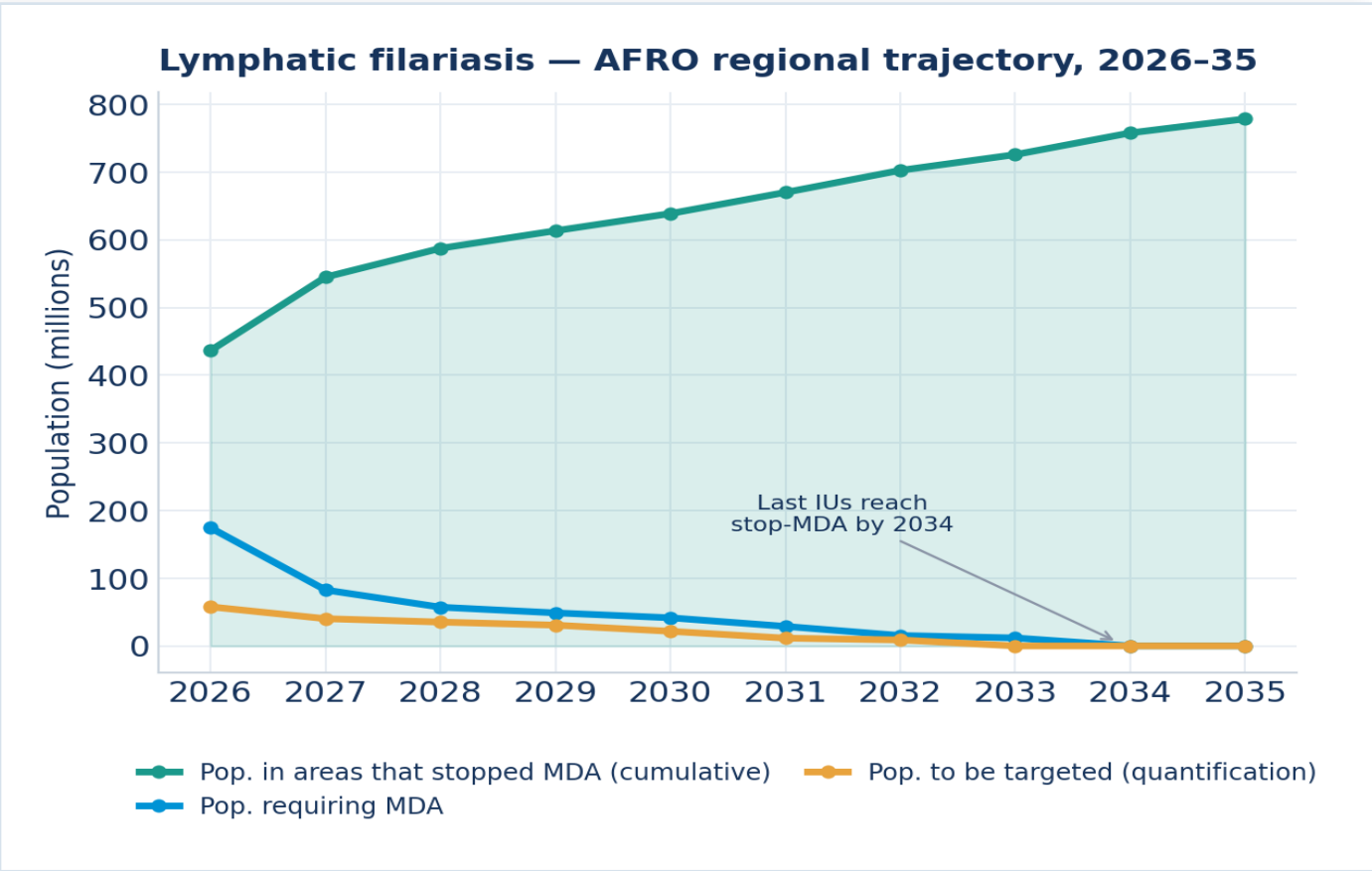
- 1 **Endemic IU requires PC** albendazole / mebendazole, age-targeted
- 2 **Treat Pre-SAC, SAC & WRA** denominators built per age group
- 3 **Set frequency by prevalence** $\geq 50\% \rightarrow 2\times/\text{yr}$ · $20\text{--}50\% \rightarrow 1\times/\text{yr}$ · $<20\% \rightarrow$ scale down
- 4 **Impact Assessment (IA)** periodic re-survey to re-classify prevalence
- 5 **Reduce frequency → surveillance** transition as intensity falls below thresholds

Target: Elimination as a public health problem (EPHP): $<2\%$ heavy-intensity

KEY ASSUMPTIONS

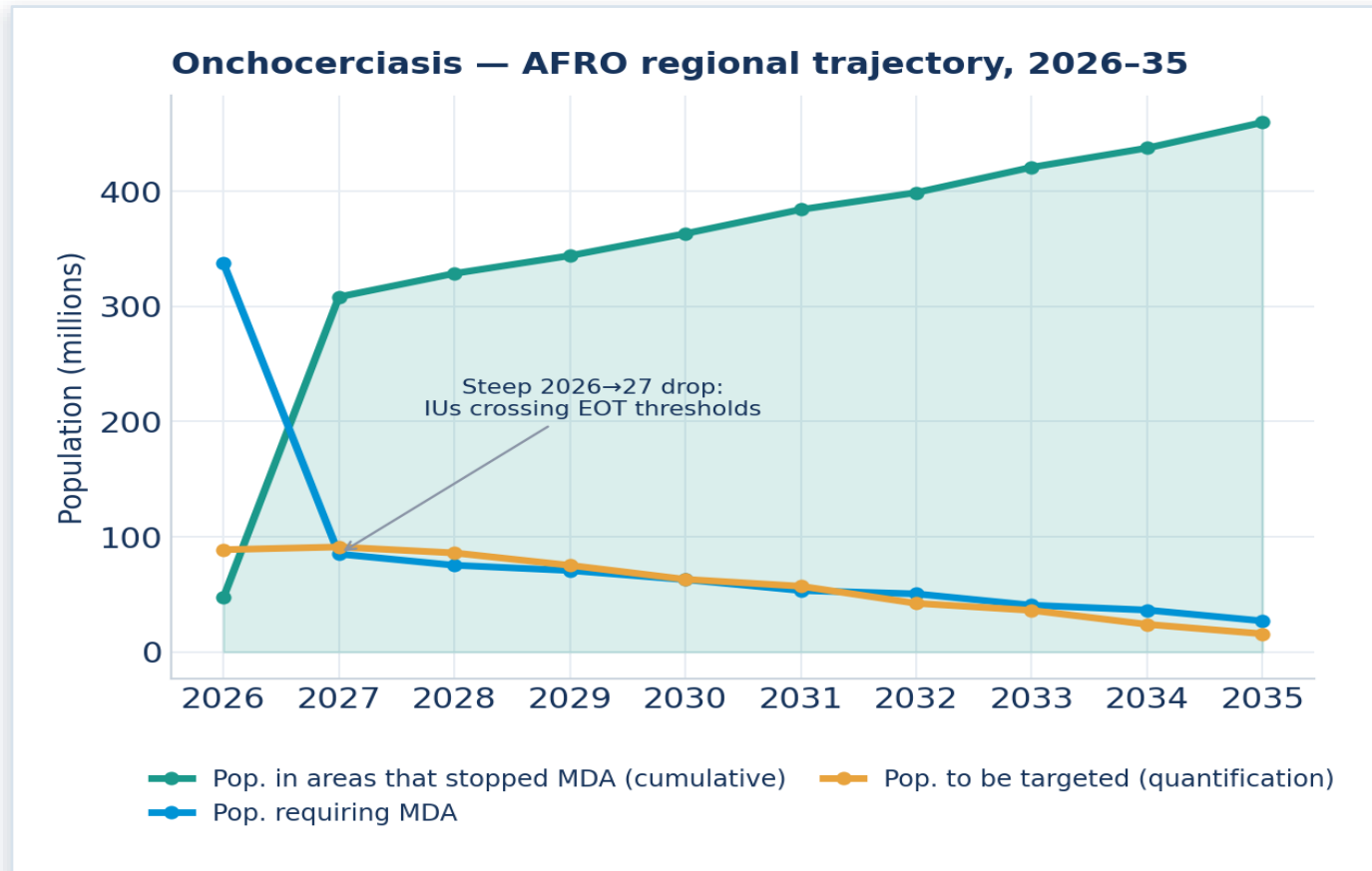
- PC delivered to Pre-SAC (1–4), SAC (5–14) and women of reproductive age (15–49)
- Treatment frequency reset by baseline / re-assessed prevalence band
- Assuming a downgrading of prevalence after each IA
- Effective PC assumed at $\geq 80\%$ coverage (*at least*) on SAC population
- No permanent 'stop': IUs step down frequency and enter surveillance
- Impact-assessment cycle (every 5 effective MDA rounds) drives the alternating target population

LF — population requiring MDA falls sharply as IUs stop treatment

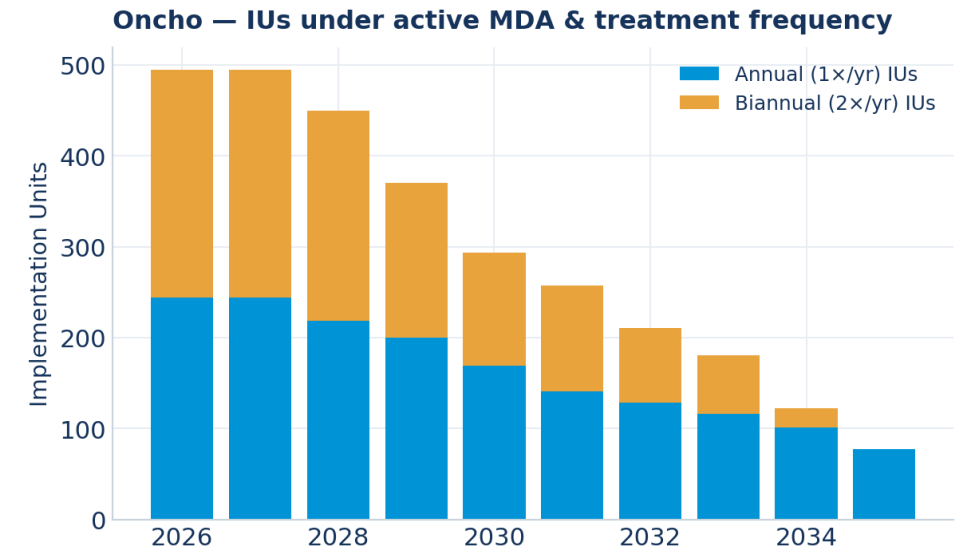


- Pop. requiring MDA: 174M (2026) → ~0 by 2034
- 778M cumulatively living in stopped-MDA areas by 2035
- Nigeria, Madagascar & DRC drive 2026 demand

Oncho — steep 2026→27 decline as IUs cross EOT thresholds

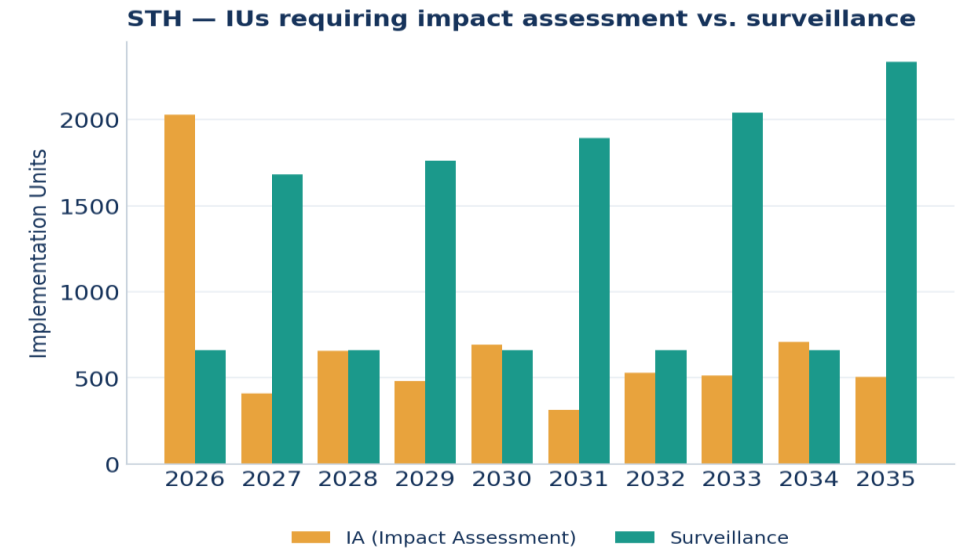
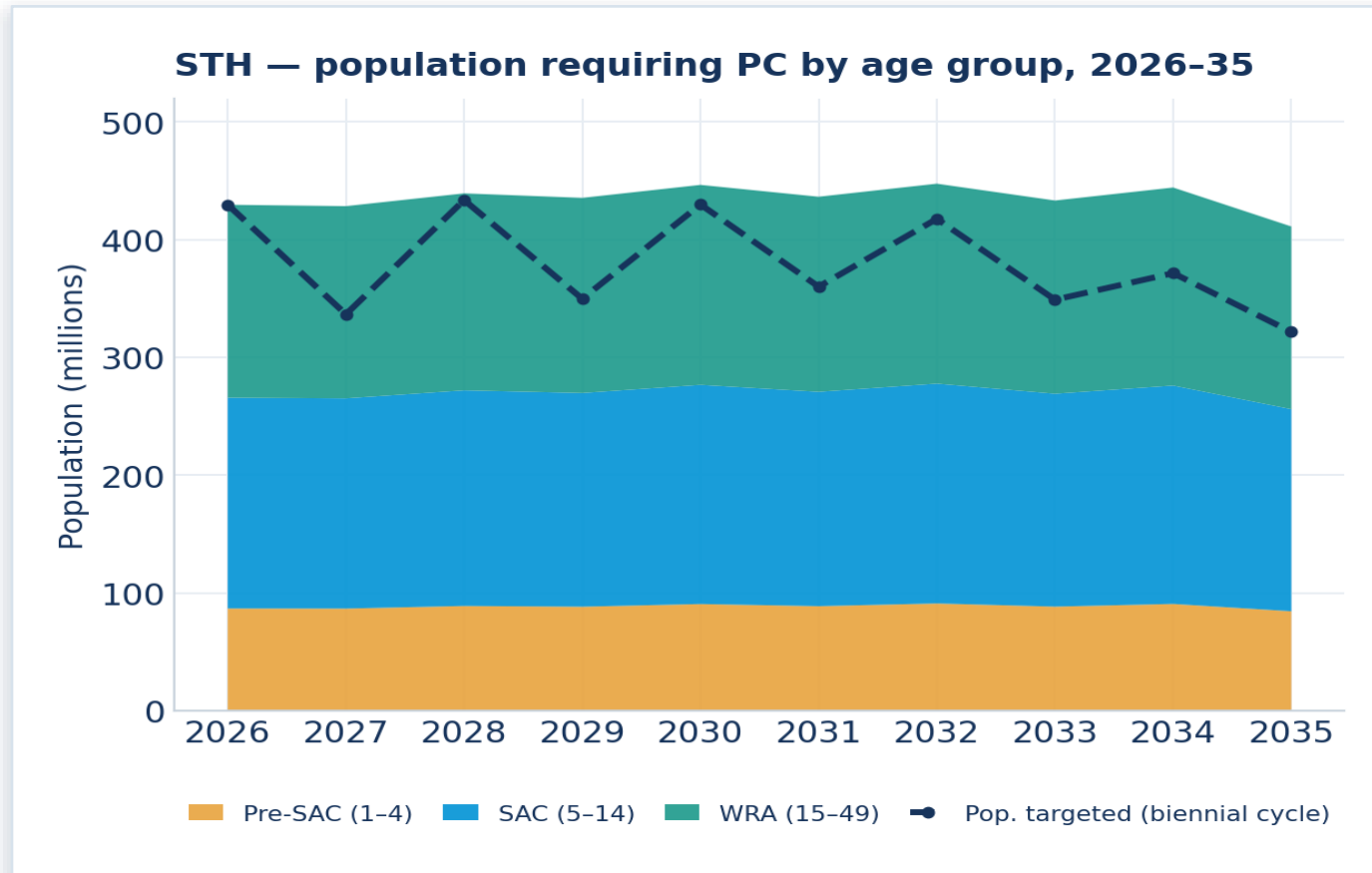


Caveat: Progression dependent on scaling up STOP surveys (>60% IU endemic for oncho have implemented ≥ 15 MDA rounds)



- Pop. requiring MDA: 337M (2026) → 27M (2035)
- Active-MDA IUs fall from ~495 to <80 by 2035
- Biannual IUs front-load ivermectin demand early

STH — sustained PC need; biennial cycle drives medicine demand



- Pop. requiring PC stays high: ~410–450M through 2035
- SAC (5–14) is the largest treated group (~180M)
- Target population alternates with the IA cycle → plan supply biennially

What the projections mean for supply chain & forecasting

Three demand signatures

LF & Oncho demand declines steeply (elimination pathways); STH demand persists and cycles — different procurement logic for each.

Plan biennially for STH

Impact-assessment cycles make even/odd years differ; align albendazole/mebendazole orders to the targeted-population rhythm.

Front-load, then taper

Donation requests for IVM/IDA peak early (2026–28) then fall — quantify the down-ramp to avoid over-stock and expiry.

Last-Mile visibility

Knowing when each IU stops MDA lets ESPEN redirect diagnostics, surveys and TA to the few remaining endemic IUs.

Conclusions

- 1 A single deterministic engine now produces harmonized, reproducible IU-level projections (2026–2035) for LF, Onchocerciasis and STH across 44 AFRO countries.
- 2 The outputs strengthen medicine quantification, MDA planning and survey scheduling with clear year-by-year trajectories aligned to the NTD Roadmap 2030.
- 3 Each disease shows a distinct demand signature — declining for LF and Oncho, persistent and cyclical for STH — with direct implications for procurement and donor planning.
- 4 By anticipating Last-Mile transitions, ESPEN and partners can target technical assistance, diagnostics and surveillance where they are still needed.

Extending the engine: sub-IU projections for schistosomiasis

Why sub-IU resolution for SCH?

- SCH transmission is strongly focal — prevalence varies sharply within a single IU, tied to local water contact.
- The 2022 WHO SCH guideline shifts treatment decisions to a finer scale and extends PC to all age groups, including adults, in high-prevalence settings.
- IU-level averages mask high-risk communities and lead to over- or under-treatment — sub-IU projections sharpen targeting and praziquantel quantification.
- Same deterministic engine, finer spatial unit: sub-district prevalence surfaces feed the SCH module.

BUILD ROADMAP

- 1 Assemble sub-IU prevalence**
SCH_Epi_Data + geostatistical surfaces
- 2 Define decision rules**
2022 guideline: SAC + adults, prevalence bands
- 3 Generate PC projections**
SCH_SubIU_PC_Projections, 2026–2035
- 4 Integrate to CDW & portal**
CHIP dashboards / ESPEN NTD Portal

Questions & discussion

- Surveillance Officer, ESPEN — WHO Regional Office for Africa



TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING
NTD Data Use, Reporting and Supply Chain
Capacity

Kintélé, Brazzaville,
Republic of the Congo

DAY 5



Health Promotion,
Disease Prevention and
Control Cluster



EXPANDED SPECIAL PROJECT
FOR ELIMINATION OF
NEGLECTED TROPICAL DISEASES



TRAINING WORKSHOP ON EFFECTIVE PC-NTDS DATA PROCESSING

NTD Data Use, Reporting and Supply Chain Capacity

ESPEN Collect 2026 new features, workflow and value

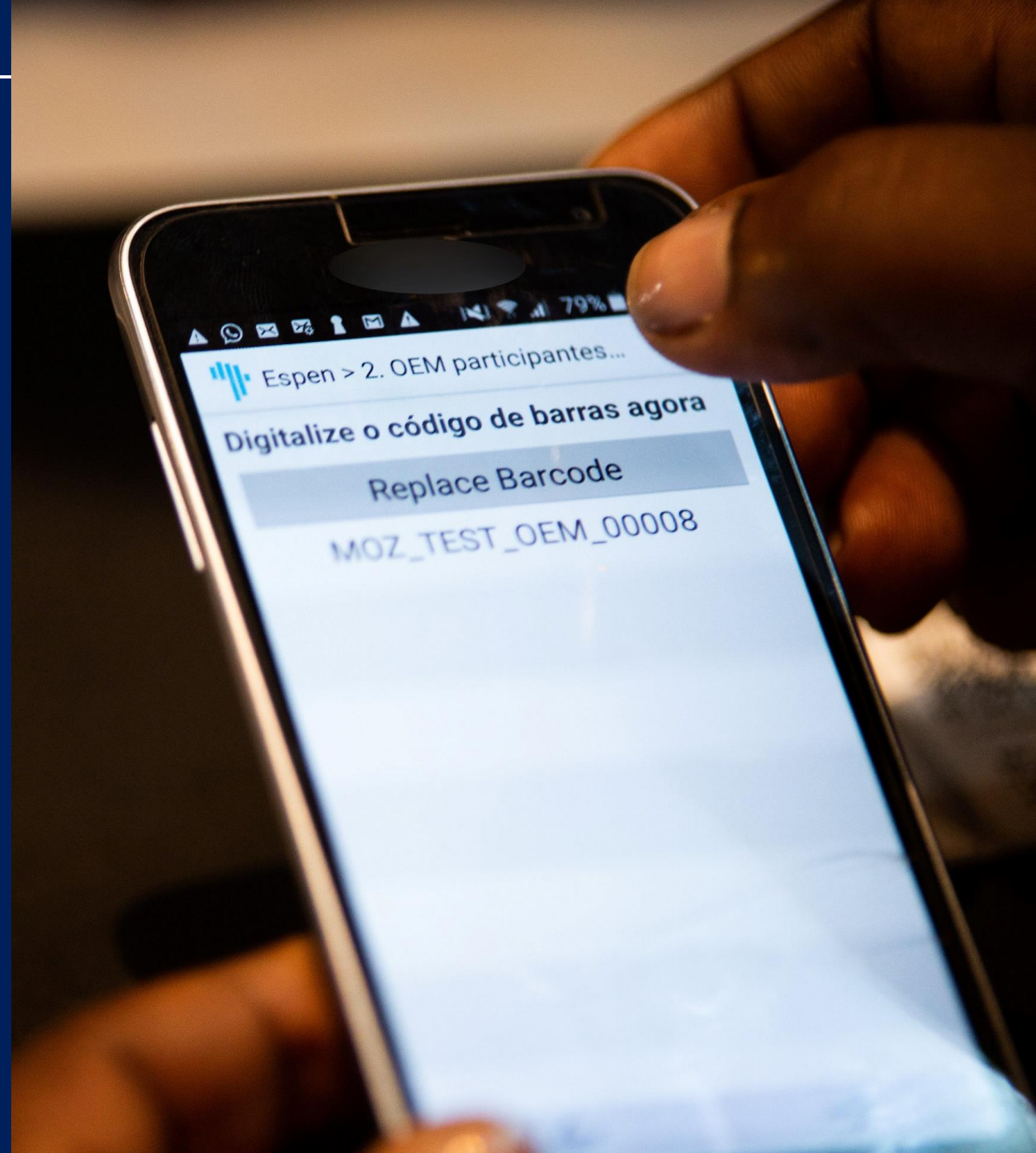
Kintélé, Brazzaville,
Republic of the Congo



ESPEN Collect Overview

*ESPEN Collect 2026 new features, workflow
and value*

Dyessa YUMBA / Levison Nkhoma



What is ESPEN Collect?

Launched

2018

No-cost access to:

- Mobile data collection tools
- Disease subject matter experts

2025–2026 Expansion

- ✓ Full survey protocol development support
- ✓ Standardised templates & checklists (LF, Oncho, SCH, STH)
- ✓ Step-by-step ESPEN Collect guide for country teams
- ✓ Data review, cleaning & validation procedures
- ✓ Streamlined EPIRF submission pathways
- ✓ All resources on ESPEN Portal & NotebookLM AI (knowledge management system)
- ✓ Integration of MDA Module of ESPEN Collect

ESPEN Support Workflow — Survey Lifecycle



📌 All survey templates available on GitHub · Training resources on ESPEN Portal · AI support via NotebookLM

Tools and resources -> Documents search

World Health Organization
African Region

N

Training Materials

01

DOC

Master Training Document

Comprehensive reference covering all ESPEN Collect survey support processes, workflows, and technical guidance for country teams.

LF Oncho SCH STH

EN / FR / PT

02

PPT

Slides for Training

Modular facilitator decks covering platform navigation, protocol templates, EPIRF workflow and reporting.

Facilitator deck

Editable PPTX

03

SOP

Standard Operating Procedure

Step-by-step procedures for survey registration, protocol submission, technical review and EPIRF submission.

Process guide

Country teams

04

TEST

Pre & Post Test

Knowledge assessment tools to measure participant understanding before and after training. Results inform post-webinar reporting.

Knowledge check

Auto-scored

05

FORM

Post-Survey Feedback Form

Structured feedback tool for countries to evaluate ESPEN Collect support quality, identify gaps and inform service improvements.

Country feedback

Service review

06

VIDEO

Training Video

Short recorded walkthroughs of the ESPEN Collect SOP

Screen recording

EN / FR

ESPEN Collect Training Materials | Available in English Francais Portugues | espen@who.int



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ESPEN Collect training materials are used to train an AI knowledge management system powered by [Google's NotebookLM](https://notebooklm.google.com/notebook/868f3e17-8db4-4ee6-8d9b-d6b64df17f3f?addSource=true) (<https://notebooklm.google.com/notebook/868f3e17-8db4-4ee6-8d9b-d6b64df17f3f?addSource=true>).

This tool allows ESPEN Collect users to ask questions and receive results that are informed by the training materials whenever they need some support.



 ESPEN Collect Training Manual v2026m1  Shared  PRO  

I collected data all day and I can't get the data to send from the phone to the server. What should I do?

First, ensure that the data you collected today is actually finalized. If you saved your forms as a "Draft," they will not be available to send. You must **Finalize** the forms first.

If your forms are finalized but still won't send, follow these steps to troubleshoot the issue:

- **Check your internet connection:** The most common reason data fails to upload is a lack of internet. Verify that your smartphone has an active Wi-Fi or mobile data connection.
- **Navigate to the correct menu:** Open the ESPEN Collect app and go to the "Ready to send" section.
- **Attempt to resend:** Select the specific forms you want to upload (or check the box to select all of them) and press the "Send Selected" button.
- **Wait for a better signal:** If the submission fails due to poor connectivity or temporary server downtime, do not worry. **Your forms will safely remain in a pending state on the device.** Simply re-attempt the upload once your internet access is restored or you reach an area with a stronger signal.
- **Follow offline end-of-day procedures:** If you cannot get a connection by the end of the day, ensure all your collected forms are finalized so they are ready for the next day's submission. Keep your device securely stored and ensure it is plugged in to fully charge overnight so you do not lose power or data.

If you have confirmed that your internet connection is strong but the app or device is still persistently malfunctioning, you should **document the problem in your daily Technical Issue Log** and immediately escalate it to your supervisor or ICT support for assistance.

Start typing... 

NotebookLM can be inaccurate; please double check its responses.

Duplicate records: same participant ID, twice

A simple uniqueness rule—backed by coordinated field practice—keeps counts and follow-up trustworthy.

A duplicate is more than one record using the same participant ID.

The ID—not the device, date, or barcode alone—is the matching key.

PARTICIPANT ID	NAME
P-1042	Yoka Awa

PARTICIPANT ID	NAME
P-1042	Jane Doe

DUPLICATE

One ID → multiple rows → review required

Why it happens

- **Human error / reduced attention:** Fatigue, repetitive data collection, or reduced attention can lead to accidental reuse or incorrect entry of a barcode
- **Uncoordinated devices:** Multiple recorders / phones at one site use overlapping ranges.
- **Code reused:** A pre-printed code is issued
- **Repeated record:** The same individual/household/site is accidentally recorded more than once
- **Incorrect code entry:** The recorder manually enters or scans the wrong barcode, resulting in a code that has already been used

Why it matters

- **Inflated counts:** Participants or denominators can be counted more than once, leading to overstated results.
- **Biased results:** Duplicates can affect endemicity or coverage estimates and other survey indicators.
- **Delayed reporting:** Resolving duplicates can delay data validation and report submission.
- **Loss of confidence:** Unresolved duplicates reduce confidence in the quality and reliability of the dataset.

Orphaned errors: one form without its linked form

ESPEN Collect splits information across forms — the Participant ID is the relationship key.

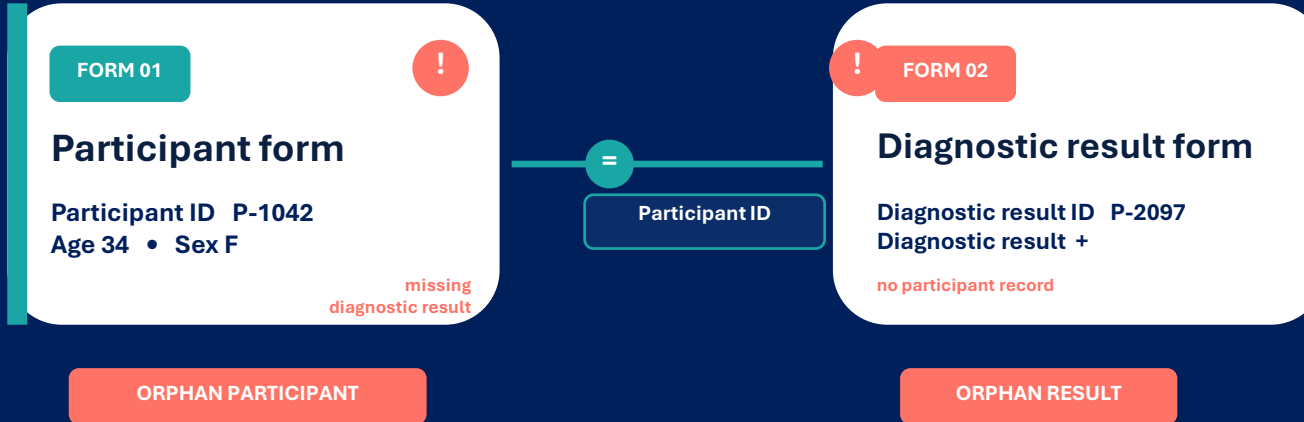
WHAT IT IS

A link breaks when one side of the two-form record is missing.

Participant form
+ Diagnostic result form

THE LINKING RULE

One Participant ID → one complete pair



THE CHECK

Every participant record should have one linked diagnostic result — and vice versa.

Same ID • two forms • one complete record

WHY IT HAPPENS

- Participant form not completed
- Diagnostic form not completed / saved
- Wrong or missing Participant ID
- Sync / import failure
- Workflow timing

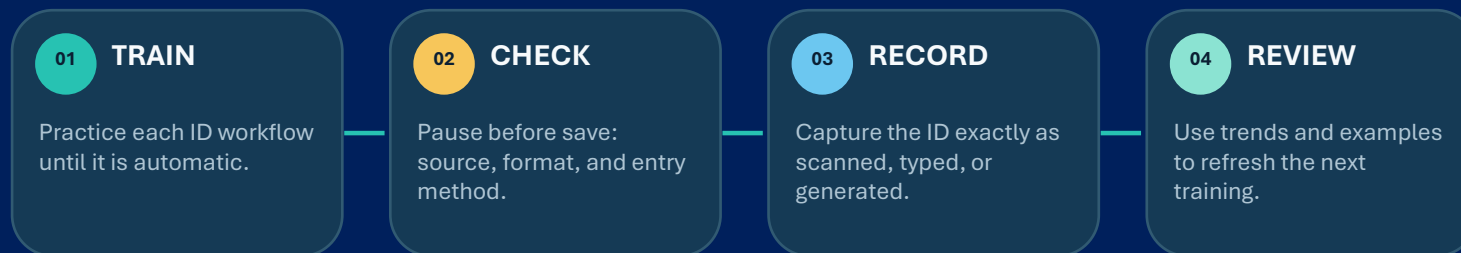
WHY IT MATTERS

- Incomplete follow-up
- Under / over-counted results
- Invalid analyses
- Delayed reporting
- Loss of confidence

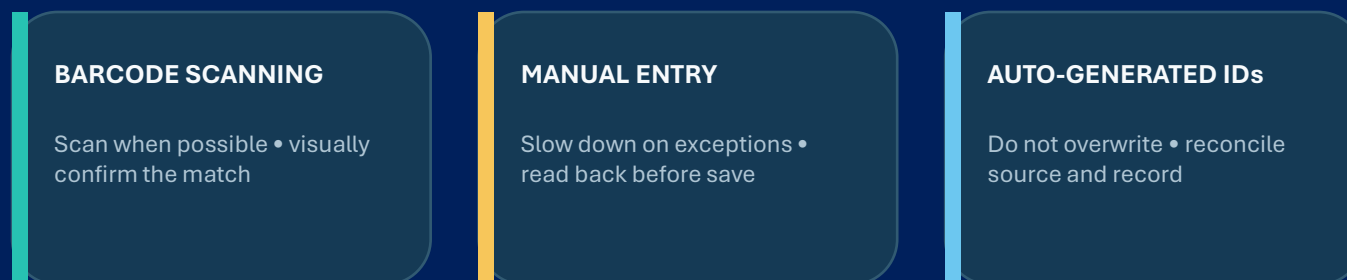
Prevent ID mistakes before fatigue turns into duplicates or orphans

A practical operating loop: repeat the workflow, verify the source, and keep the signal visible.

PREVENT Make the safe path the repeatable path



WHAT GOOD LOOKS LIKE



SUPPORTING SAFEGUARD
Form validation checks format, length, and required fields — helpful, but not a substitute for trained handling.

THE HUMAN CONTROL

Repeated practice + a deliberate pause are the strongest defence against fatigue-related mistakes.

DETECT

Keep the signal visible



METABASE DASHBOARD

Monitor duplicates by site, source, and trend.



REGULAR EMAIL ALERTS

Share exceptions and actions on a set cadence.

1. Campaign Overview

Total Population	Eligible Population	Total State	District	Health Facility	Location
14,026	12,758	4	8	16	96

2. Medicine Distribution



Best Practices — Barcode & Auto-Generated ID

How to prevent duplicates and orphans across the ESPEN Collect data-collection workflow.



Barcode / QR code

Structured, self-describing pre-printed code (Country_IU_Survey_Site_N°)

- Ensure high-quality, high-resolution printing; redesign labels to avoid doubled codes.
- Isolate the code before scanning; confirm the displayed value matches the physical label.
- Define a manual fallback for codes that will not scan — then verify the entry.

Best for: new ESPEN Collect users; sites using several phones.



Auto-generated ID

Recorder_Site_Order N° (e.g. 99_123_01) — site & recorder readable

- Continue the order-number sequence across days — never restart at 1.
- Allocate distinct ID ranges per team and per district / site.
- One recorder / one phone per site; verify the displayed ID before proceeding.

Best for: experienced teams; constrained logistics / tight budgets.



Golden rules for both approaches

- ✓ One unique recorder ID per team member.
- ✓ Use only the ID given by the supervisor; enter participants in chronological order.
- ✓ Record all participants / results from a site before finalizing; use “Save as draft” to resume.
- ✓ Clear cache & delete old forms before each survey; include form-entry exercises in training.

6 2026 Achievements

52 Survey supported in 16 countries

41 coordination and technical meetings — 2026

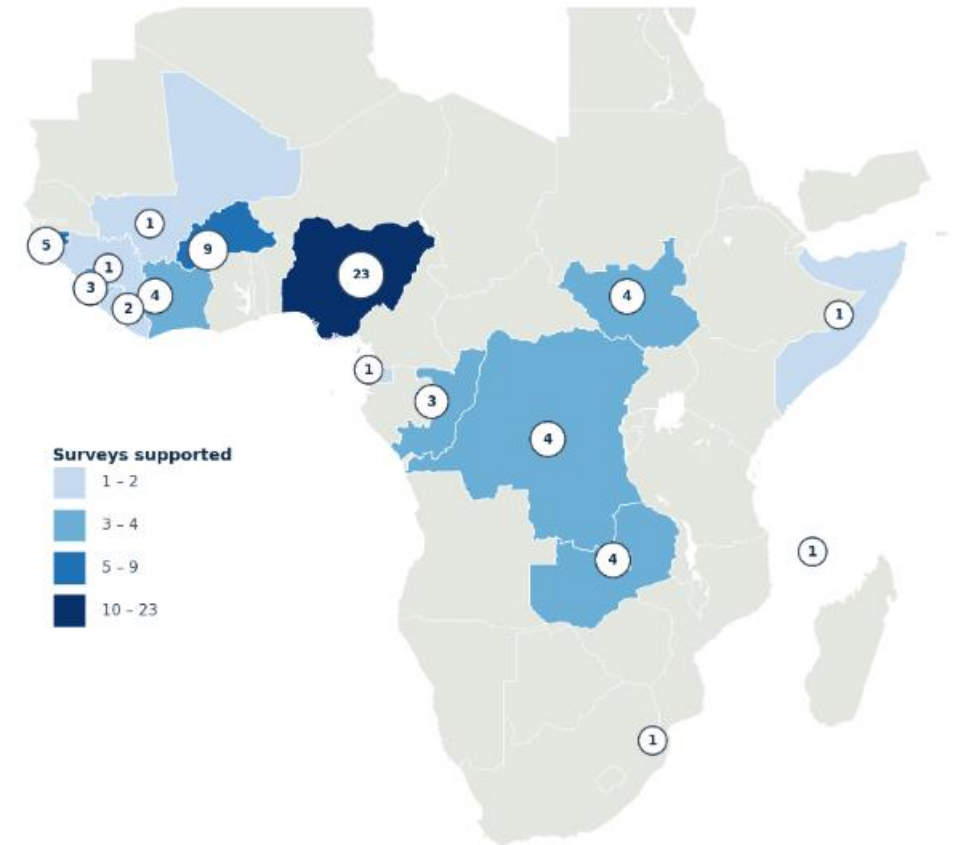
29 protocols reviewed across 14 countries

36

EPIRF generated & reviewed

31

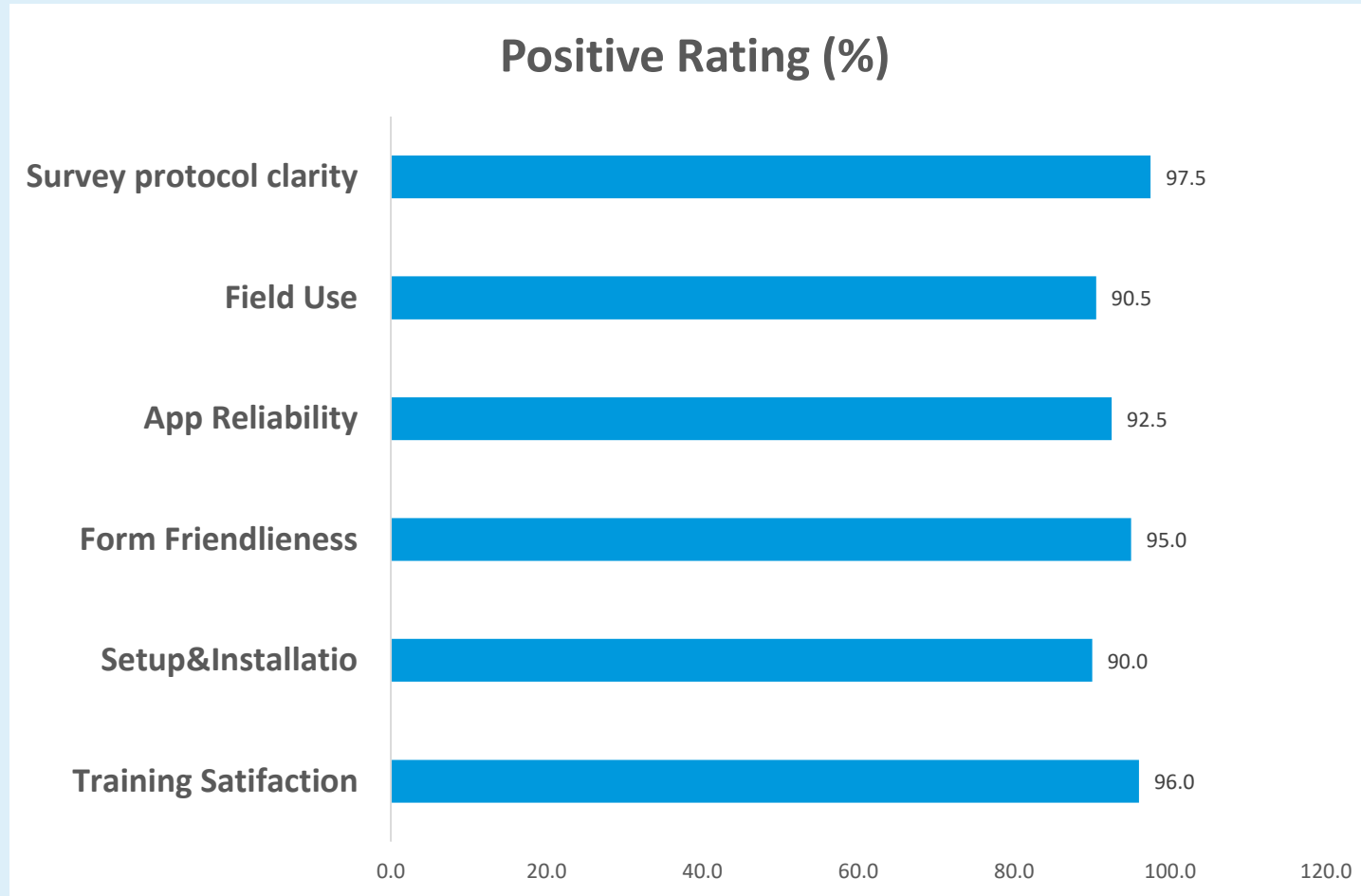
Submitted on ESPEN Portal



ESPEN Collect — Geographic distribution of supported surveys

Feedback received on post-activity survey

Participants reported high satisfaction across all aspects of ESPEN Collect surveys (90–98% positive ratings)



Key Findings

- Overall satisfaction exceeded **96%** across all domains.
- **Survey protocol clarity** received the highest rating (**98%**).
- **App reliability** (93%) and **form friendliness** were rated highly (**95%**).
- Participants reported that the platform was easy to install and use in the field (**90%**).
- Training received excellent feedback (**96%**).



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Country Ownership and Data Integration in ESPEN Collect

WHO hosts the data while ensuring full country ownership, secure access, and integration into national systems

WHO Data Hosting

- WHO securely hosts ESPEN Collect data
- Provides infrastructure and data protection
- Ensures availability and system reliability

ESPEN Collect Platform

- Data stored in PostgreSQL relational database
- Centralised data management system
- Real-time data collection and storage
- Integrated with Metabase for data visualisation

Country Ownership and Access Control

- Data belongs to the country
- Countries decide who can access the data
- Access managed securely via Metabase dashboards
- Control over access level and timing

Integration with National Systems

- API available for data integration
- Enables connection with national databases
- Supports long-term use and sustainability

Thank you !

For more information, please contact:

ESPEN Support

Email: espensupport@who.int



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75⁺
HEALTH
FOR ALL





**TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING**
NTD Data Use, Reporting and Supply Chain
Capacity

**New MDA Module — Video
Walkthrough**

Kintélé, Brazzaville,
Republic of the Congo



ESPEN Collect MDA Pilot



Thank you !

For more information, please contact:

ESPEN Support

Email: espensupport@who.int



World Health
Organization

75⁺
HEALTH
FOR ALL



AI for supporting NTD survey protocol Review



What AI can do — and its red lines

✓ AI CAN help you...

- Check the completeness and internal consistency of the protocol
- Flag potential ethical and methodological issues for human review
- Help draft the protocol, checklists and JobAids

⊘ AI must NEVER use to...

- Make a scientific or ethical decision on your behalf
- Receive identifiable participant data or sensitive program data (de-identify first)
- Receive budget



Golden rule

AI assists, Disease Expert decide : Every AI output is reviewed, edited and approved by humans.

What we want to answer — and what we need to answer

? 3 questions to answer

- 1 Is my country protocol compliant with WHO requirements?
- 2 What improvements are needed to meet them?

📁 what we need to answer



Protocol



ESPEN Guidelines / checklist



Prompt



AI model

Gemini, Claude, Perplexity, ChatGPT...

How to proceed in 4 steps

1

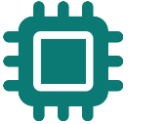
Check the red lines



De-identify: remove any identifiable or sensitive data before importing anything.

2

Choose an AI model



Gemini, Claude, Perplexity, ChatGPT....

3

Import the documents



Protocol + reference document into the tool.

4

Paste the prompt & run



Launch the review, read the compliance score and table, then iterate.

LIVE DEMO : SCH and STH impact protocol review

Review SCH and STH protocol

1. Import SCH and STH protocol share with into AI tool
2. Download and Import ESPEN SCH and STH checklist
3. Copy and paste the prompt into AI tool
4. Check IA output

Before / after, always.

AI proposes — Human to validate and decide

> **EXAMPLE PROMPT:** *Persona · Task · Context · Format · Iteration structure*

PERSONA

You are a senior NTD survey methodologist and protocol reviewer, fluent in WHO manuals & ESPEN guidance for **[SCH and STH Impact assessement]**. You are rigorous, objective and constructive. You apply only the thresholds, definitions and rules stated in the reference document; you never invent figures, thresholds or data

TASK

Review the attached **[Murkunia]** **[SCH and STH]** **[Practical Assessment]** protocol against ESPEN compliance checklist. Work through the protocol section by section. For EVERY checklist section item, without exception rate YES or NO. For every NO, give ONE specific, actionable fix, referenced to (a) the protocol section to change and (b) the checklist/manual section that requires it

CONTEXT

[DOC 1] Murkunia SCH and STH Practical Assessment protocol

[DOC 2] ESPEN SCH and STH Compliance checklist- criteria to be scored

FORMAT

1) Summary score: count YES/NO; weighted YES=1 NO=0, as X/Y + %.

2) Table: item · rating (YES/NO) · recommendation for no rating.

Language: English, plain, objective. Never invent data/thresholds.

ITERATION

"Now produce a one-paragraph summary on protocol compliance with only overall score and Key revisions are needed."

Doc 1 : [Example of SCH STH Protocol](#). You can use also DSA guidelines or protocol

Doc 2 : <https://espen.afro.who.int/tools-resources/documents/sch-and-sth-survey-basic-protocol-compliance-checklist-en-fr>

LIVE DEMO : SCH and STH impact protocol review

1) Summary score

Compliant items: 23 / 38 = 60.5% (weighted YES = 1, NO = 0).

Checklist section	YES	NO	Items
A - Basic information	3	2	5
B - Survey purpose & type	3	0	3
C - Programmatic context & PC history	1	3	4
D - Survey design & methodology	11	0	11
E - Ethical & operational compliance	3	4	7
F - Budget & logistics	0	2	2
G - Expected outputs & data use	1	2	3
H - Support from ESPEN	1	2	3
Total	23	15	38

LIVE DEMO : SCH and STH impact protocol review

2) Item-by-item rating

2) Item-by-item rating

#	Checklist item	Rating	Recommendation (for NO)
A-1	Country	YES	—
A-2	Submitting institution	YES	—
A-3	Contact person (name, title, email)	NO	Complete the <i>Item Information</i> table — add PI name(s), title and a working email; "missing data" placeholder is not acceptable for submission.
A-4	Date of submission	NO	Insert the submission date in the <i>Item Information</i> table (currently "DD/MM/YYYY — missing data").
A-5	Implementation partner (if applicable)	YES	—
B-6	Purpose of survey (IA1, ≥5 y PC)	YES	—
B-7	Target disease(s) — SCH + STH	YES	—
B-8	Implementation unit(s) — district level	YES	—

C-9	PC distribution history (5 y, coverage by round)	NO	§1.1/§2.1 — add a year-by-year table of PC rounds with epidemiological coverage per round for each district; "at least 5 rounds" is asserted, not documented.
C-10	PC coverage achieved ≥75% (Y1–Y5)	NO	§2.1 — provide documented coverage figures per year per district to substantiate the ≥75% claim, so each year can be ticked from reported data.
C-11	Additional interventions (WASH, SBC)	NO	§1.1 — describe WASH/SBC interventions already delivered in the districts, or mark <i>Unknown</i> with rationale; current text only lists WASH/SBC as a future recommendation output.
D-12	Survey method (Practical IU-level assessment)	YES	—
D-13	Justification for method (mandatory)	YES	—
D-14	Survey area (district)	YES	—
D-15	PSU (school)	YES	—
D-16	PSU selection (systematic + random)	YES	—
D-17	Sample size calculation provided	YES	— (provided with SOS-study basis; but internally inconsistent — see §3)
D-18	Age group targeted (5–14 SAC)	YES	—



LIVE DEMO : SCH and STH impact protocol review

2) Item-by-item rating

D-19	Diagnostic methods (KK 2 slides; dipstick + 10 mL filtration)	YES	—
D-20	Quality control plan	YES	— (data QC described; lab QC is thin — see §3)
D-21	Geo-referencing of sites	YES	—
D-22	Data collection tools attached	YES	— (ESPEN Collect forms attached; referenced KK/urine SOPs and training materials are not attached — see §3)
E-23	Ethical approval process mentioned	NO	§6 — add a paragraph on the ethical review pathway (submission to national ERC and WHO-AFRO ERC, since ESPEN-Collect/WHO support is sought), with expected timeline.
E-24	Informed consent / assent plan	YES	—
E-25	National ethical approval obtained	NO	Cover/§6 — state the national ERC submission status and expected clearance date ; no approval is evidenced in this draft.
E-26	Field team structure & responsibilities	YES	—
E-27	Field team training plan	NO	§2.6 — add a training plan: duration, content, Kato-Katz standardization / inter-reader agreement , urine filtration SOP, and ESPEN Collect training.

E-28	Laboratory capacity assessed & adequate	NO	§2.5/§2.6 — add a lab capacity assessment (available microscopes, trained microscopists, daily slide-reading throughput vs. workload) and adequacy status.
E-29	Plan for positive-case treatment	YES	—
F-30	Detailed budget attached (required)	NO	§7 — attach a line-item budget ; the section is currently empty/marked optional, but the checklist makes it mandatory.
F-31	Logistics plan (transport, storage, consumables)	NO	§2.6 — add a consolidated logistics plan: transport, sample storage/handling , and consumable/reagent quantities and procurement; current text mentions transport and waste only.
G-32	Data analysis plan (M&E Framework indicators)	YES	—
G-33	Commitment to upload raw data to ESPEN Portal	NO	§4 — add an explicit commitment to upload raw, record-level data to the ESPEN Portal; current text limits sharing to de-personalized site-level data via EPIRF (aggregate). Using ESPEN Collect (H-35) facilitates this.
G-34	Timeline for implementation & reporting	NO	§2.6.2 — replace "[specify the indicative period]" with a dated timeline / milestones for fieldwork, analysis and reporting.
H-35	Using ESPEN Collect	YES	—
H-36	Requesting financial support from WHO	NO	§7/Section H — state explicitly whether WHO financial support is requested; if not, name the funding source.
H-37	Requesting diagnostic kits from WHO	NO	§2.5/Section I — state whether Kato-Katz kits, Hemastix and filtration supplies are requested from WHO, or specify the

LIVE DEMO : SCH and STH impact protocol review

3) One-paragraph summary

One-paragraph summary

Overall compliance is 22/37 (59.5%). Key revisions are needed to complete the protocol's administrative information, provide the required five-year PC history and coverage documentation and historical survey data, strengthen the documented quality-control, training and laboratory-capacity plans, obtain/document national ethical approval status, add the detailed budget and logistics plan, explicitly commit to raw-data submission to the ESPEN Portal, provide the implementation/reporting timeline, and state the arrangements for WHO financial and diagnostic-kit support; the internal sample-size inconsistency should also be corrected before submission.

Time & quality gains: manual vs AI-assisted review

Manual review

3–4 days

- Section-by-section cross-check against the WHO/ESPEN checklist or M&E manuel, by hand
- No compliance score : just comments
- Feedback delays to the disease expert and the country

AI-assisted review

< 10 min

to the first compliance draft • **≤ 1 day total**

- Draft score + item-by-item table generated in under 10 minutes
- Freed time goes to human check compliance and engage disease-expert review and validation
- Full cycle compliance check completed within one day maximum

Net gain ≈ 2–3 days saved per protocol in protocol compliance check and provide summary finding for Disease expert validation
Quality: more consistent coverage (every checklist item rated, nothing skipped) with recommendations traceable

Your turn!

Your mission — 10 min

- Open your protocol + the WHO reference document
- Remove any identifiable data (red lines)
- Choose an AI model and import both documents
- Paste the prompt, run it, then read the compliance score

What you'll produce



A compliance

Count of YES/NO, weighted YES=1 NO=0, as X/Y and %.



A recommendations table

One row per item: item · rating (YES/NO) · actionable fix.

Bonus. Ask the AI for a one-paragraph summary (iteration), then check every recommendation against the WHO manual before accepting it.



Always remind : AI proposes — Human to validate and decide

Hands on : The reusable prompt and context

Everyone can work on this independently

1. Use own country protocol
2. Check the red lines any remove any identifiable or sensitive data before importing anything
3. Import ESPEN checklist or Disease M&E manual
4. Adapt and Use reusable prompt, copy and paste into AI tool
5. Reflection - did it work. Share your finding with the team

>_ EXAMPLE PROMPT: *Persona · Task · Context · Format · Iteration structure*

PERSONA

You are a senior NTD survey methodologist and protocol reviewer, fluent in WHO manuals & ESPEN guidance for [DISEASE]. You are rigorous, objective and constructive. You apply only the thresholds, definitions and rules stated in the reference document; you never invent figures, thresholds or data

TASK

Review the attached [TAS1] protocol against the WHO manual LF 2025 manuel checklist . Work through the protocol section by section. For EVERY LF Manuel [TAS] section item, without exception rate YES or NO. For every NO, give ONE specific, actionable fix, referenced to (a) the protocol section to change and (b) the checklist/manual section that requires it

CONTEXT

[DOC 1] Country [TAS1] protocol

[DOC 2] LF 2025 M&E manual [TAS] section - criteria to be scored

FORMAT

1) Summary score: count YES/NO; weighted YES=1 NO=0, as X/Y + %.
2) Table: item · rating (YES/NO) · recommendation for no rating.
Language: English, plain, objective. Never invent data/thresholds.

ITERATION

"Now produce a one-paragraph summary on protocol compliance with only overall score and Key revisions are needed."

LF 2025 M&E manual : <https://espen.afro.who.int/tools-resources/documents/monitoring-and-epidemiological-assessment-mass-drug-administration-global>

Auto Evaluation



Please scan the QR code to complete your self-evaluation exercise.



TRAINING WORKSHOP ON EFFECTIVE PC-
NTDS DATA PROCESSING
NTD Data Use, Reporting and Supply Chain
Capacity

Post-test

Kintélé, Brazzaville,
Republic of the Congo

