Rethinking MDA campaigns: Leveraging integrated health campaigns for improved effectiveness and impact.

International Conference on Neglected Tropical Disease Research in Africa (InCORNTD), Kigali, Rwanda

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Contents

Description and Aims:

The rapidly evolving global health funding landscape has significantly reduced resources available for schistosomiasis (SCH) control and preventive chemotherapy Neglected Tropical

diseases (PC-NTD) mass drug administration (MDA) campaigns. As a result, countries are often forced to prioritize which vertical disease campaigns or monitoring and evaluation surveys to implement, frequently pausing or abandoning activities until new funding can be secured. This jeopardizes the success and impact of these programmes.

In response to these challenges, public health programmes are exploring alternative approaches to delivering health campaigns and optimizing available resources. This breakout session, led by Dr Anouk Gouvras, drew on the talks presented during the InCORNTD Technical Symposium in the Plenary Session (see summary in Annexe 1) and three additional talks (see slides in Annexe 2):

- 'A paradigm shift from parallel, top-down, vertical disease control programmes to integrated, locally relevant, evidence-based and sustainable health campaigns. Example of helminth treatments with malaria chemoprevention in West Africa' by Dr Muhammed Afolabi, London School of Hygiene and Tropical Medicine.
- 'Integrating NTD processes into a national electronic community health system (eCHIS) and Ministry of Health Integrated Campaign Delivery (ICD) platform in Kenya' by Florence Wakesho MoH Kenya.
- 'Approaching integration and codelivery using a sustainability lens' by Wendy Harrison, Unlimit Health.

The session examined different models for delivering preventive chemotherapy for schistosomiasis and other NTDs, leveraging existing health platforms. This included group activities aimed at identifying factors, barriers and challenges that contribute to the success, or otherwise, of integration strategies, explored the metrics and monitoring processes required to track progress on health deliverables, and considered the policy recommendations and health system strengthening approaches required to enable the development and uptake of integrated health campaigns that address PC-NTDs. The discussion emphasized country-driven approaches and national ownership. It explored the possibility of translating a potential crisis into an opportunity to improve sustainability and health services.

Three group activities:

- Activity 1: What do we know about integrated PC codelivery approaches?
- Activity 2: What are the metrics for evaluating integrated co-delivery progress in health programs?
- Activity 3: What do we need to strengthen integration and codelivery for sustainable public health interventions?

The breakout session aimed to pinpoint the critical implementation and operational research questions needed to strengthen SCH, soil-transmitted helminthiasis (STH), and NTD integration and coordination with national and subnational health campaigns. The outcome is to help identify areas for improvement, enhance programme impact, and ensure effective progress tracking of health outcomes.

Summary of priorities:

Building the evidence for integrated, codelivery campaigns:

There is a pressing need to build the evidence, using mixed-methods, clear metrics, and cost-effectiveness analysis to show the potential of, and appropriately advocate for, integrated models of delivery. The evidence can help guide the development of frameworks and toolkits for integrated approaches, help drive enabling environments for integrated effective campaigns that can progress to strengthen health systems. Research could:

- Develop frameworks and methodologies to identify campaigns and platforms where integration is beneficial for both NTDs and non-NTD programmes:
    - Define what is being measured – safety, acceptability, cost, capability & capacity indicators, delivery mechanism indicators, quality of life indicators, epidemiological indicators.
    - Develop cost-benefit and cost-effectiveness analysis models to test different integration options to identify what would be a best-buy in a particular context.
    - Use research pilots to capture data-evidence that fits context and is locally relevant.
    - Bring in innovations for new approaches (integration with one health, use of technologies).
- Conduct research to strengthen and expand evidence on safety, acceptability, feasibility of co-administration[1] of drugs.

Creating an enabling environment and culture for integration of PC-NTD interventions with non-NTD campaigns and routine services:

At the global, national and local level there is a need to build a policy and investment ecosystem that supports cross-programme coordination and integration of health campaigns, which can eventually lead to integration with primary healthcare. Key items include:

[1] A note on co-delivery and co-administration – in this document we use "co-delivery" to mean the distribution of treatments/interventions for health conditions using the same platform and resources; co-administration refers to giving more than one treatment at the same time point.

- At the global level develop a high-level policy brief or recommendation for integrated co-delivery campaigns for PC NTDs.
- Develop policies on designing a coordination framework which enables clear roles on who is the decision-maker, how governance works, clarity on roles and responsibilities. Draw on existing guides and tools, such as the Collaborative Action Strategy for Campaign Effectiveness (CAS) from the Health Campaign Effectiveness Coalition.
- Support MoH to:
    - Build data systems that enable interoperability.
    - Develop a checklist/cheat-sheet on criteria for integration, and on metrics that need to be measured through existing integrated data systems.
    - Conduct situation analysis, stakeholder mapping and campaign mapping to guide coordination framework for integrated interventions.
    - Map technical expertise, identify gaps and build expertise across the integrated platforms - communicating and consulting with the health workforce
    - Develop community engagement strategies that build trust and acceptability of integrated codelivery programmes.
- Advocate to governments, funders/donors and NGOs for flexibility in their structures and systems to allow for integrated, codelivery approaches, building on commonalities in the problems/challenges faced by different programmes, and how integrated approaches may address these common challenges, how integrating NTD interventions will add value and improve outcomes and sustainability.
- Financial environment - There is a need for data on what is being funded and what investments are coming in, by whom. Capturing the investments from MoH is important to external donors, as is giving MoH visibility of the funding of NTD activities and epidemiology, this will support and increase domestic resource mobilisation (DRM).

GLOBAL SCHISTOSOMIASIS ALLIANCE

Report from breakout group activities:

Activity 1: What do we know about integrated PC codelivery approaches?

1. What examples/case studies do you have from your context of integrated PC delivery?
2. What were the drivers and expected benefits behind these integrated delivery approaches?
3. Can you share some of the barriers to implementation, to scale up, to sustainability from these examples?

The groups discussed experiences of the co-delivery of PC treatments, across NTDs and leveraging non-NTD health campaigns and routine health services, with experience of diverse platforms of delivery. For a list of the examples and experiences shared in the groups, please see Annexe 3.
The following re-occurring points were raised as drivers, benefits considerations and barriers to integration approaches:

1. **What examples/case studies do you have from your context of integrated PC delivery?**

Examples: Examples of integrated PC included those with: other PC NTDs; other NTDs; other infectious diseases; Non Communicable Diseases (NCDs); other health priorities or issues and also One Health approaches with overlap with animal programmes targeting their owners.' For a list of the examples and experiences shared in the groups, please see Annexe 3.

2. **What were the drivers and expected benefits behind these integrated delivery approaches?**

Drivers: Necessity due to lack of funding for praziquantel (PZQ) distribution. If there is strong motivation at the higher government & MoH leadership level, e.g. for effective campaigns, self-sustainability and ownership, this can be a strong drive for integrated and cross-cutting interventions. Another driver is when more than one programme identifies commonalities between programmes, whether common challenges or approaches, and build on that. Local leadership can also drive integration, for example in devolved systems or when local leadership is engaged with health and development challenges in their constituencies.

Benefits: Cost-saving is seen as the biggest benefit and ability to demonstrate increased cost-effectiveness of campaigns is an important driver. Cost-savings could be made through combined training programmes covering the training needs of several interventions. Another benefit discussed was reducing campaign fatigue in communities requiring multiple public health interventions if these interventions are done in an integrated and coordinated manner, rather than stand-alone interventions. Integrated delivery could improve delivery to hard-to-reach populations by combining efforts and resources across programmes. Another benefit mentioned was that combining delivery of treatments could leverage public perception and prioritization of a particular disease or treatment, increasing compliance to other treatments/interventions that are perceived to be less of a priority. An example given was that in certain communities, PZQ is given more value than albendazole, so combining the two means more albendazole is taken up.

Considerations: Participants highlighted several important considerations such as the health workforce, and how they perceived integrated strategies. Community health workers may see the benefit of integration in terms of better coordination between programmes, meaning less confusion, but there may also be a perceived disadvantage with the risk of being overwhelmed with work, and the increased workload not being recognised through incentives. Looking at the manuals, guidelines and toolkits used by programmes and platforms, including data management tools, would be a key step to strengthening coordination and integration between these programmes.

Cost-benefit analysis is required around integration with routine service delivery to look at the use of drugs and how integration optimizes resources. Furthermore, the different services, programmes and platforms need to be looked at carefully, regarding their ability to reach target populations – does this include hard-to-reach populations (nomadic/pastoralists, non-enrolled SAC, including urban and peri-urban street children etc) and do some platforms perform better with these special groups e.g. mobile populations could leverage One Health programmes focused on cattle and animal health e.g. nomadic herders and migrant populations? An important piece is on stakeholder and community engagement, communication and dissemination of information. Engaging local leadership is key and is working tailoring to the contexts and communities, consider the diversity of contexts and communities, do different platforms perform better for some groups over others? Discussion included if this integration approach for PC delivery could also involve coordination with different sectors such as WASH and agriculture to better share data and utilise these to strengthen tailored, locally led solutions.

3. **Can you share some of the barriers to implementation, to scale up, to**

sustainability from these examples?

Challenges/Barriers: Participants discussed the barriers and challenges raised by the bureaucracy and siloed operationalization of programmes. Reluctant or disengaged MoH leadership can be one of the biggest barriers to integrated interventions to deliver NTD treatments. The programme leads may also be hesitant if it is not clear who is responsible for the integrated programme, who organizes, pays and takes decisions? There can be a fear of losing ownership of the disease programme and jeopardising gains.

Logistical challenges were discussed, with participants recognising that different cycles of programming, differing supply chain management, different data collection tools, have resulted due to the traditionally siloed approach to these programmes. Diseases also have different monitoring and evaluation, and surveillance, requirements and processes. Changing platforms (school vs household vs facility-based) due to using an integrated delivery approach may lead to challenges on coverage. Training was repeated as a barrier if health workers from different programmes are not familiar with PC NTDs, with ensuring quality of training being raised as an important consideration. The impact of donor pressure and donor inflexibility was highlighted as a potential barrier. Finally, the participants discussed how challenges could mean that two programmes may have been stated as integrated "on paper" but in practice operated as two distinct programmes working alongside each other. Barriers included lack of trust in records and processes, non-defined hierarchies for decision making, lack of communication and compromise.

Activity 2: What are the metrics for evaluating integrated co-delivery progress in health programs?

1. What metrics need to be captured during the implementation stage, through coverage evaluation and through impact assessments (data types: treatment coverage, geographical coverage, acceptability, compliance, epidemiology, cost, quality-control etc)?
2. What metrics need to be shared with relevant stakeholders e.g. to meet the WHO medicine donation criteria and supporting organisations, and what needs to be standardized?
3. What data can be fed into models to assess effectiveness, cost effectiveness and impact of different co-delivery approaches vs standard vertical approaches?

Participants discussed the metrics and indicators for evaluating the effectiveness of PC delivery through integrated campaigns and health services. Participants discussed types of the data, the data collection processes/tools and data management requirements in the context of integrated, co-delivery programmes and platforms, and how to evaluate the cost-effectiveness of these approaches. A key discussion item that was repeatedly raised was the question of how to identify the appropriate platforms for integration of PC delivery.

1. **What metrics need to be captured during the implementation stage, through coverage evaluation and through impact assessments (data types: treatment coverage, geographical coverage, acceptability, compliance, epidemiology, cost, quality-control etc)?**

What processes & impact are we measuring and how will data be managed?
Participants discussed different types of indicators and metrics for integrated, codelivery campaigns, including having comparators in place e.g. from pilot areas or baseline coverage data and appreciating that the number of indicators and amount of data to collect needs to be balanced and appropriate to the end goal. Participants discussed the importance of differentiating integration of data systems by looking at service delivery vs epidemiological assessments given differences with interventions, implementation units vs evaluation units and ensuring systems have interoperability.

- <u>Input indicators</u>
    - Consider the input indicators required for each "element" of the integrated delivery – are there specific PC NTD indicators that need to be added?
    - Financial resources, operational policies, Leadership/ownership.
    - Products (drugs, vaccines, diagnostics).
    - Consumables for delivery – antiseptics, food for taking praziquantel etc..
    - Human resources, including training and supervision resources.
- <u>Process indicators</u>
    - A key metric must capture planning at all levels and synchronization.
    - Drug supply indicators.
    - Compliance to intervention/ uptake of treatment.
    - Measure systematic non-adherence.
    - Capacity strengthening/building metrics -Fidelity of training - Is the training and supervision being done properly? Who will monitor this? Is the workload acceptable?
    - Data need to be collected on the acceptability of drug co-administration, and metrics on the acceptability of integrated co-delivery campaigns for communities, CHW, programmes, and funding agencies/donors. A mixed methods approach is needed to collect these data.

    - Data tools and management systems – linked to this information and communication technologies.
    - Safety reporting – record severe adverse events (SAEs).
    - Comprehensive data for coverage evaluation – geographic and demographic, how much of the target population has been reached.
- Impact/Output indicators
    - Quality of life indicators (comparable across diseases and health issues).
    - Morbidity indicators (disease specific and non specific).
    - Epidemiology (prevalence, intensity of infections) (disease specific measures).
- Other metrics
    - Can data be collected on behaviour patterns regarding reinfection risk?
    - Carrying out screening in areas with co-morbidities before treatment to be able to evaluate how these comorbidities may change with a codelivery intervention.
- Strategies
    - Modification of coverage surveys.
    - Integrated training to deliver and capture data and associated process metrics.
    - Consider how combining results from sentinel and/or impact surveys to monitor prevalence and intensity of infection, alongside coverage and compliance data, can be used to observe patterns of infection and coverage over time.
- Data and data systems
    - Data tracking forms – paper-based or electronic e.g. electronic community health platform eCHIS/integration of tools.
    - Data systems? E.g. DHIS2?
    - For any mobile platforms, offline capability is key for resource-limited environments.
    - How could AI be further leveraged for measuring integrated co-delivery?
    - Data training on the new elements and the different data types needed to be collected to help reduce workload and overall cost.
    - Importance of real-time data collection.
    - Identify the commonality (what and when) of data collected as well as distribution platform.

2. **What metrics need to be shared with relevant stakeholders e.g. to meet the WHO medicine donation criteria and supporting organisations, and what needs to be standardized?**

Criteria and considerations to identify appropriate platforms

Participants discussed the criteria when identifying potential campaigns/platforms for codelivery of PC, could these be developed into a checklist or guide:

- Do the target populations align? By age group, sex, geography etc..
- Do the cycles of intervention align?
- What is the performance and coverage of the campaign/platforms?
- How is the campaign/platform perceived by the community? Is it trusted? Is there good compliance?
- What type of delivery platform is used?
    - School or community based,
    - Door-to-door approach,
    - Combination of platforms,
    - Facility-based (target population comes to the platform).
- What are the logistical implications for integration for each campaign/platform:
    - Supply of products – drug availability, storage, transport, expiry, etc.,
    - Training strategy,
    - Outreach, communication and mobilization,
    - Administration and governance/decision-making hierarchy.
- Are there clear benefits for integrating programmes? What benefits could integration with PC-NTDs bring to the other programmes? What are the potential challenges?
- What impact indicators are collected by the programmes? Is there an alignment of agendas and goals?
- How are hard-to-reach populations dealt with and are never-treated individuals identified?
- When looking at integrating with other drug-based or vaccines-based interventions, what is known about the drug-drug interactions, safety, spacing/timeliness, and tolerance of co-administration and co-delivery of these interventions?
    - What are the adverse effects of all drugs/vaccines used in isolation and in combination?
    - Are there safety data on co-administration of the drugs/vaccines?
    - Do the conditions of their administration align? E.g. give with food or on an empty stomach? Etc..
    - How many drugs/vaccines can you co-administer/co-deliver safely and logistically without affecting acceptability? WHO has some guidance, is this enough?
- What are the existing reporting needs of the different platforms and programmes? Can they be aligned, can PC NTDs be integrated into these reporting structures?

Challenges and opportunities

- Challenge of lack of specific guidance or recommendations for integrated codelivery campaigns for PC NTDs.
- There is an opportunity to use the Collaborative Action Strategy for Campaign Effectiveness (CAS) from the Health Campaign Effectiveness Coalition – has this been used with PC NTDs?
- There are general guidance documents, that are not disease-specific but are relevant, in place at Africa CDC & African Union Commission (AU). MoHs also cover overarching diseases via health systems strengthening, and so many policies are not disease-specific but focus on Universal Health Care and cascade down to primary health care. But it is the funders, NGOs and researchers who often bring the single disease control programme focus/silos.
- Bring innovation in the thinking of integration, think out of the box, not necessarily only of human treatment and MDA programmes to integrate with, e.g. integrating with veterinary health and animal treatments programmes or agricultural programmes may increase the reach of treatment distribution to pastoralists, nomadic and migrant populations.
- Can donors be encouraged to be more flexible with programmes and with reporting to encourage integration, can donors share the message that integration is encouraged and can be reported in data?
- Can indicators be linked to incentives for the health workforce?
- Could there be specific research into fixed drug combinations that could lead to an effective single dose?

3. **What data can be fed into models to assess effectiveness, cost-effectiveness and impact of different co-delivery approaches vs standard vertical approaches?**

Cost-effectiveness analyses

- What data are needed to run analyses on the cost-benefits and the cost-effectiveness of integrating schistosomiasis, soil-transmitted helminthiasis preventive chemotherapy with other routine health campaigns? Need to test multiple options and platforms?
- What are the costs? List:
    - Logistics of integration may take longer,
    - Longer timelines for implementation and data collection,
    - Community health worker training,
    - Community health worker incentives,
    - Increased number of workdays of CHW,
    - Volunteer incentives.

- What are the benefits? List:
    - Reduce fragmentation – improve coordination between stakeholders and health agendas,
    - More efficient use of limited resources - rather than several siloed, vertical programmes, one main health campaign that covers several health goals, a more holistic approach to health intervention delivery,
    - Reduce campaign fatigue in target population,
    - Opportunity to improve denominator,
    - Opportunity to strengthen health services and reporting.
- What are the risks? List:
    - Complex logistics,
    - May lose coverage of target groups,
    - May increase non-compliance,
    - May lead to a need for further funding.
- Consider context when looking at cost-benefit/ cost-effectiveness.
- If considering integrating a test & treat strategy into local health facilities, then data on cost-effectiveness and feasibility are required.
- Consider running pilots with potential campaigns/platforms – use these to collect necessary data to validate cost-effectiveness models and for advocacy to local, national and international levels.

Activity 3: What do we need to strengthen integration and co-delivery for sustainable public health interventions?

1. Policy/Governance: Building on the barriers identified in Group Activity 1, what policy changes might be needed - at the national level, at the local level and globally?
2. Financing: As external funding decreases, what is needed to advocate for co-delivery models at the country level? What do partners need to do to support this and advocate at the international level?
3. Workforce: What does this mean for the health system, including community workers, campaign workers, outreach programmes, volunteers, health service staff?

Participants discussed the need to build evidence, use metrics and data and cost-effectiveness analysis to show the potential of, and where appropriate advocate for, these integrated models of delivery, to guide the development of frameworks and toolkits for integrated approaches, and to build enabling environments for integrated effective campaigns that can progress to strengthen health systems.

1. **Policy/Governance: Building on the barriers identified in Group Activity 1, what policy changes might be needed - at the national level, at the local level and globally?**

Building the evidence for advocacy

- To identify the appropriate programmes and platforms for integration, stakeholder planning and engagement is key. This needs to include looking at how aligned the implementation plans are, where are the potential intersections and tailoring this based on endemicity. E.g. looking at malaria, Mpox, HPV vaccines etc..
- Therefore, there needs to be a context-specific approach, that can be used to make more general policy recommendations, driven from the local level up to the national, a bottom-up approach. Using a context-specific landscape analysis at local/district/IU level to see what could work, then advocate using such data to the national level? The evidence for advocacy can come from data driven from bottom-up, with positive, enabling policies and national budgetary structures from the top-down.
- There is a need to build the research evidence to influence national, international and funder buy-in. However, this does mean that there is a need for funding to build the evidence.
- Incorporating cost-effectiveness analysis to strengthen the evidence is key.
- Data from pilot projects could help to motivate:
    - Senior management to integrate,
    - Building integrated programmes that have durable benefits,
    - Strengthening data on safety, accessibility etc.,
    - Ownership of data (by MoH or devolved stakeholders where appropriate),
    - Influencing and advocating at the national and international level.

Policy Recommendations and coordination frameworks

- Policy recommendations are needed at government level to encourage multisector coordination & integration of programmes. Policies could include developing a coordination framework which enables clear roles on who is the decision-maker, how governance works, clarity on roles and responsibilities. Models of integration which have these coordination frameworks and include toolkits could be developed.
- Governance structures need to be clear: when programmes work together, if there is a conflict how is it resolved? Is there a hierarchy of integrated programmes? How is this decided? When working with devolved systems, who are the decision makers? At what level do they work and what data are they using to prioritise campaigns and diseases? Could NTD indicators be added to district level data to help with

prioritisation? Guidance on how to build and define these structures could be very useful.

- A key learning from countries with integration experience is that the leadership within programmes, eg. MoH at the highest levels, and cross-sector ministerial working groups is key, including the conviction to self-sustain. Once policies are in place, then politics play an important role on how much money the policy/ies get. It is important to involve political levels that have an umbrella position in the system.
- Governments have their own fragmentation within programmes. Cultural tendencies within these groups could lead to assumptions that further integration will lead to reductions of funds overall. Building motivation for integration may be needed. Donors should offer flexibility, such as including workforce capacity building and incentives for integrated interventions and developing sustainable models. Situation analyses could help inform integration approaches and coordination mechanisms.
- There is a need to carefully map and build technical expertise across the integrated platforms; identify the needs and propose solutions (integrated needs assessment) and plan to eventually move from integrated health campaigns to integration with health systems.
- There is a need to work with Health Systems Strengthening experts, inviting these experts to WHO NTD meetings, InCORNTDs breakout sessions, etc to learn from these experts and accelerate integration progress.
- An important consideration when trialling integrated approaches is to allow for a "route-back" or shift to coordination rather than full integration, if the full integration model does not meet the set goals. This will encourage governments and funders to trial different models of integration, capture lessons learned and adapt to appropriate models.

Communication and advocacy

- Communication and advocacy could include:
    - Messaging to governments, to donors, to encourage flexibility of programmes.
    - Capturing the risks if programmes and campaigns do not integrate – risks to all programmes and to MoH.
    - Find commonalities in the problems/challenges faced by different programmes & look at how this can help with advocating for pilots for integrated approaches that address these common challenges
    - Important to communicate that integration with other diseases/campaigns will not jeopardize the disease-specific national and global goals e.g. malaria elimination.

    - Integrate with resources – what can NTDs bring to integrated interventions that will add value and convince other programmes?
- The Africa CDC structure can be leveraged to drive policy recommendations regionally.
- To obtain an international mandate (WHO) for integration member states need to have the evidence. The ask can come from member states. Countries can use their influence if they have the evidence.

Community engagement: Community involvement and ownership is key for the success and sustainability of integrated programmes**.** MoHs need to be willing to engage with communities, to provide opportunities for community input, being clear on what interventions will be delivered, why, how and when. Engaging with local social scientists/ communities/philanthropists/civil societies who can help advise on culture to enhance intervention implementation would also be useful.

2. **Financing: As external funding decreases, what is needed to advocate for co-delivery models at the country level? What do partners need to do to support this and advocate at the international level?**

Financing: Participants discussed challenges with financing, for example districts still expect financing to come from MoH but MoHs expect districts to build integrated codelivery approaches into their existing budgets.
Opportunities could involve counterpart funding, if a donor is investing X – what is the country investing? There is a need for data on what is being funded, by whom. Visibility of data to MoHs of NTDs will support and increase Domestic Resource Mobilisation (DRM). Capturing the investments from MoH is important. There is an international level expectation of transparent joint budgeting. At the same time, there is a need for donors to adapt to MoH timelines rather than the other way round, to facilitate budgeting and reporting on integrated campaigns. Capacity building needs to be included in budgeting and reporting progress. Digitization of tools could facilitate further integration with data management as a key integration consideration. Participants discussed the need to build domestic funding and the need for innovative ways to generate the funds. How can funding sources be diversified? And looking at national versus devolved systems, where are budgets decided? If at the district level, how is stakeholder mapping and coordination supported here?

3. **Workforce: What does this mean for the health system, including community workers, campaign workers, outreach programmes, volunteers, health service staff?**

Workforce:

- Community health workers (CHW) will expect that increased workload will be linked to extra incentives, the input, feedback and needs of CHW should be sought as this has a clear impact on costs and quality of service, quality of delivery, and quality of data. Can non-financial incentives be used? Career development for CHW? E.g CHWs e.g.60,000 in Rwanda, but when MDA comes around the Community Drug Distribution budget is often the biggest. So, can MDA be written into the CHWs job descriptions? Would they then complain of too much work, focused on only a few days a year? And how will training be provided and expenses covered?
- Volunteer roles such as community drug distributors also need to be considered if used. Status and formal recognition of a role for volunteers? Can incentives be linked to indicators? Is there a need to move away from the volunteer force?

Annexe 1

Technical Symposium: Health systems integration for schistosomiasis and NTDs

Chairs: David Rollinson and Fiona Fleming introduced the technical symposium highlighting four questions that the symposium would explore: i) What factors drive the success of integration?; ii)Understanding these factors what processes need to be developed to successfully integrate NTD services into existing delivery platforms?; iii) How can the impact of integrated approaches be monitored to ensure progress to global goals is being captured?; iv) What are the perspectives of partners, funders and large-scale agencies of integrated, co-delivery approaches?

First Prudence Beinamaryo, the schistosomiasis and soil-transmitted helminthiasis lead from the Ministry of Health, Uganda presented a new case study on the codelivery of praziquantel through Child Health Day campaigns in Uganda. This approach was developed following a shortage of funds for MDA implementation whilst still needing to distribute 14,211,000 praziquantel tablets to more than 4.5 million people before the tablets expired at the end of 2024. The MoH and partners looked at existing alternative platforms of delivery that could be leveraged and used a set of criteria including alignment between target group(s) and potential cost-effectiveness measures, then identifying the key

stakeholders to engage and advocate to get the right approval and support from all levels of the MoH. Prudence highlighted the following:

- Success:
    - Buy-in from MOH and district stakeholders,
    - Integration of PZQ MDA and iCHDs took place in all the planned districts,
    - Integrated delivery of supplies and logistics up to the last mile was achieved,
    - Close supervision of MDA activities in the districts was supported by this project,
    - Medicines were utilized and saved from expiry.
- Challenges:
    - Inadequate training on PZQ dozing and data collection. There was limited time,
    - Limited manpower during the implementation to deliver all the interventions and document all the data,
    - Delays in reporting PZQ data.
- Recommendations:
    - Comprehensive training of all health workers in PZQ administration and reporting,
    - Add extra personnel per team to support the vaccination team,
    - Increase advocacy for integration at all levels,
    - Phased integration approach,
    - Need to have some little funding to support supervision to enable a follow up.

The second talk was a recorded talk by Kristing Saarlas and Teshome Gebre from the Taskforce for Global Health on the Health Campaign Effectiveness (HCE) Coalition, an innovative coalition that seeks to change the fragmented health campaign ecosystem. The HCE Coalition has undertaken research in 15 countries, demonstrating the benefits and best practices associated with better coordinated and integrated campaigns. This has led to the development of the Collaborative Action Strategy for Campaign Effectiveness (CAS), including 12 recommendations that fall under Planning & Implementation, M&E/Monitoring, Evaluation, Research, Learning, and Adapting (MERLA) and Campaign Financing. The CAS aims to support countries to increase integration and reduce the number of overall campaigns and increase effectiveness and transition to the primary health care system. Two countries are implementing CAS – Ethiopia and Nigeria. Nigeria is using a new tool for campaign mapping & integration, including decision-making and planning considerations. The Health Campaign Effectiveness Coalition welcomed NTD programme

managers and supporting partners to contact them for more information on CAS via **https://campaigneffectiveness.org/**

The third talk was by Dr Aimable Mbituyumuremyi from the Rwanda Ministry of Health and Rwanda Biomedical center, presenting Rwanda's work on coordinating NTDs with malaria and Child Health Week Campaign. The MCH Week campaigns consist of 8 coordinated components: malaria prevention, antenatal clinics, health facility delivery, family planning, breastfeeding for first 6 months, full vaccination profiles, malnutrition screening and WASH and MDA for schistosomiasis and soil-transmitted helminthiasis. The coordination mechanism uses three steps: Prepare, Fund and Implement, and implementation arrangements include three platforms of delivery: Community, School and Health facilities, delivered by 60,000 community health workers. Dr Mbituyumuremyi highlighted new work to move health data reporting to a digital platform, the Integrated Community Electronic Medical Record (C-EMR), which includes household registration, campaign data, i-CCM, fever management, individualized drug administration, dashboard for M&E, MDA drug stock management and more.

Dr Carlos Torres-Vitolas from Unlimit Health presented the fourth talk on measuring metrics of integrated approaches, presenting on research in progress in Uganda working with the ministry of health on distributing praziquantel through the Integrated Child Health Days. The approach used includes:

1. MDA supervision: to monitor the implementation of PZQ treatment deliver through the iCHD – metrics include: coverage, planning, training, supply chain, social mobilization.
2. Process evaluation: evaluate the implementation of integrated PZQ with iCHD and the factors that shaped the outcomes – a mixed methods approach should be used to asses: to what extent was the implementation process adhered to, according to the planning, did all stakeholders engage with the process as expected, what contextual drivers affected the implementation process, and how much did the observed outcomes affect the overall interventions impact?
3. Coverage evaluation: validate the coverage of school aged children relative to the coverage targets, using the CES WHO methodology with some modification. Measures included: Coverage, Reach, Validation, Equity, Acceptability and Preference.
4. Policy evaluation: identify the policy barriers and facilitators for the integration of PZQ into the iCHD platform. Assessment looked at the extent to which existing normative frameworks enable or hinder integration, what are the gaps in the existing normative frameworks for PZQ integration into iCHD, what policy measures support long-term sustainability and scale-up of integrated MDA campaigns.

Dr Torres-Vitolas shared initial lessons which include:

- Significant time needed to review and adapt existing M&E systems and tools
- Decentralised implementation, where decisions are made at the district-level, require flexibility with the setting up of M&E activities.
- More observation time and examination is required of M&E activities when PZQ is delivered in an integrated programme.
- Info on the broader programmatic context is needed for interpretation of disease-specific metrics.
- A mixed-methods approach is necessary to capture the complexity of integration operations, including multiple stakeholders and implementation levels.

The final talk was given by Julia Battle from UNICEF Rwanda Country Office giving a UNICEF's perspective on integrated campaigns/ codelivery of NTD interventions. The talk covered the following questions:

1. What does UNICEF think of integrated, co-delivery approaches? For UNICEF, the integrated co-delivery approaches offer a more joined-up way to target and address the major causes of illness and death among children, potentially driving down costs whilst addressing co-infection/co-endemicity and increasing equity by reaching the most in need. This can reduce campaign fatigue in communities and target populations. However, we need to be clear about what we mean by integration, do we refer to integrated health services or integrated health campaigns? Integrated co-delivery approaches align with the UNICEF mandate: UNICEF work aims to contribute to the reduction of the burden and impact of NTDs, leveraging its cross-sectoral programmes - health, nutrition, WASH, education, and social policy, and cross-cutting functions in supply/ procurement/ logistics, social behaviour change, digital and advocacy/communications guided by different policies and strategies linked to the agency goals and the SDGs
2. What aspects appeal to UNICEF as investments? The approaches that guide UNICEF's work are Equity (leaving no one behind), Health Through Life Course as a continuum (holistic delivery of health services that cover the well child, the ill child and health during preconception, pregnancy, through adolescence and into adulthood), and Integrated Platforms (community-based, school-based, facility-based; cross-sectoral linkages across health (child health, immunization, maternal health), nutrition, education, and WASH). The talk highlighted examples of UNICEF Nigeria contributions to onchocerciasis and LF elimination integrated with WASH programmes in 12 states, UNICEF Uganda support to integrated EPI + NTD campaign in Uganda, November 2024, Integrated delivery of polio campaigns with additional antigen and MDA interventions.

3. And what can UNICEF do to support these approaches? Review delivery platforms and update with currently available services and linkages, examples were given of the rollout of the malaria vaccines for 0-24 months, the 'Big Catch Up' campaign which could explore opportunities to co-deliver deworming with immunization catch- up campaigns, booster doses for tetanus and diphtheria for the 4-7- and 9–15-year-olds, could this include deworming? And support regular inter-programme collaboration and coordination between NTD, polio, immunization, and malaria to jointly agree on and co-deliver interventions via identified platforms and well-child visits. UNICEF added that they are interested in implementation research needed to generate the operational evidence for combinations that work best, how to institutionalize them, how can these approaches be more sustainable, what metrics need to be measured through existing integrated data systems, can a cheat sheet be put together for integration for national programmes?

Annexe 2

Slides from Breakout session Rethinking MDA campaigns: Leveraging integrated health campaigns for improved effectiveness and impact.

The breakout session slides and facilitation sheets for the group activities can be accessed through this link.

Annexe 3

List of the examples and experiences shared in the groups for Activity 1 of the Breakout session

Examples

- **Senegal**: Example of Seasonal Malaria Chemoprevention (SMC) plus SCH & STH Preventive chemotherapy in Senegal. Considerations: Safety – are there side effects due to PZQ prior to giving SMC, awareness and sensitization before this is important. SMC is popular in communities, which benefits the acceptability of PZQ.
- **Uganda**: Immunizations, Vitamin A, PZQ and Albendazole through Child Health Days in Uganda. Driver MoH mandate because of limited resources. Human resources, staggered delivery outreach, VHTS +CDDs. Risk of community fatigue. Drug combinations IVM + ALB = one drug. Challenges: Risk is coverage falls and additional funding is needed. Safety profile – integration fear of side effects - Side effects due to PZQ again something to consider, needs revisits and creating awareness of the need to eat before taking PZQ to minimize side effects.

- **Rwanda**: Child and maternal week campaigns reach adults and children with PZQ and albendazole – communities value PZQ more so combining is a benefit for acceptability to albendazole. Need to also engage community leaders about prevalence in adults of both malaria and NTDs.
- **Ethiopia**: 16 health packages plus MDA coordination and integration. Deworming with Vitamin A campaigns. Driver-challenge is that training can be 80% of implementation cost.
- **Kenya**: Agreement at all levels is crucial. Challenge - data collection tools are not the same. Be clear on responsibilities. Stagger social mobilisation. Human resources can be overwhelmed. Example of integration of FGS with sexual and reproductive health programmes – lots of symptoms overlap, use cervical and infection screening. A major challenge is that PZQ is not available even if diagnosed as infected with schisto. Main benefit is that many of these women had never had sexual health care before, so this also increased the uptake of the programme. Example of eCHIS + community Health Toolkit : To start with, registers and data chain were inconsistent, lack of accuracy, or missing. Kenya is implementing a new system with eCHIS and community health toolkit which enables tracking individuals through the system including non-compliance and never treated. Previously there were denominator issues but eCHIS uses community registers for up-to-date population. The pilot has led to coverage 70% -65% . They are including CDD geotagging of which areas are covered.
- **Benin**: Integration has been attempted but so far this has not succeeded, not the same targets for age groups – extending age groups is needed.
- **Malawi:** Experience of Iron + folic acid integration = routine service. Coverage is an issue and there are data management needs.
- **Nigeria**: Example of integrating FGS training and minimum service package, building to include FGS training and schisto, within national training regimens.
- **Madagascar**: There has been some integration of the training curriculum supported by The End Fund
- **Sudan**: programmes need to consider community diversity– there are multi -ethnic groups which may require more tailored approaches focused on community engagement – this would include integrated approaches
- Disease examples:
    - Trachoma, one health integration with mobile/migrant populations via their cattle and the veterinary Health office.
    - STH and Schisto the older integration, initially done as *S. mansoni* and STH co-diagnosed and a common sanitation association for transmission, but with different diagnostics this becomes less common and less needed.
    - Female Genital Schistosomiasis integrated training for nurses and reproductive health professionals, working in primary health facilities and in sexual and reproductive health programmes.