

A conversation with Lynsey Blair, October 16, 2014

Participants

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Note: These notes were compiled by GiveWell and give an overview of the major points made by Dr. Lynsey Blair.

Summary

GiveWell spoke with Dr. Lynsey Blair of the Schistosomiasis Control Initiative (SCI) as part of its process to update its review of SCI. The conversation was intended to better understand SCI's work in general and to look at Mozambique as a case study to better understand SCI's role, impact, and need for additional funding.

Mozambique program

Given her role overseeing SCI's DFID-funded ICOSA program, Dr. Blair's knowledge of the program in Mozambique is largely influenced by what is reported to DFID and what is shared by USAID and RTI.

Mozambique background

Prior to SCI's involvement in 2010, there was a mapping project in 2008. Dr. Blair does not think there were any schistosomiasis (SCH) treatment programs (other than a small program funded by SCI). If there were, they would have been small-scale.

Mapping was done partly by SCI and partly by a local organization. It was overseen by Yaobi Zhang, who was working for SCI and now works for Helen Keller International.

Mozambique partnerships

The SCH program in Mozambique is run by the Center for Neglected Tropical Diseases (CNTD). Funding for the program is provided to SCI by DFID, and SCI funds CNTD as part of its agreement with DFID. CNTD's program manager for Mozambique submits timesheets to SCI on what s/he has been working on. SCI has no say over whom CNTD employs.

There have been some issues with communication and monitoring and evaluation (M&E). For example, in a previous treatment round, the CNTD program manager reported to SCI that there would be 10 million SCH treatments. Later, SCI learned that there were only 6 million SCH treatments. This was the correct number of treatments to give based on the prevalence data found during mapping, but the

praziquantel (PZQ) supplied was much greater than what was actually needed and this caused issues with SCI's reporting to DFID. The excess PZQ will be used next year.

CNTD has recently restructured internally and this has led to an improved working relationship with SCI. CNTD will continue to run the mass drug administration (MDA), but SCI has become more directly involved with the M&E as it has the SCH technical expertise to manage these activities.

SCI and CNTD are working closely with RTI International in Mozambique. RTI has staff in-country and communicates with SCI and CNTD on issues arising, which can provide some verification that the program is progressing as expected. The organizations coordinate to ensure multiple sources of funding aren't allocated for the same purpose. For example, RTI emailed SCI and CNTD saying that the government had indicated that neither SCI nor CNTD were going to support sentinel site data collection for SCH and requested this support from RTI. The staff from the organizations communicated quickly to sort out the confusion.

Mozambique reported coverage rates

RTI has a new tool for data quality assessment that looks at a few indicators at multiple levels of the aggregation (e.g. district-level and national-level). SCI and CNTD are in early discussions with RTI about including some SCH program indicators to future process checks, including within Mozambique.

This type of data quality checking is important. For example, there was a case in Tanzania where the reported treatment was high but the sentinel site data indicated that there had been very little health impact. When the register data from these schools was reviewed, it was found that some schools had not been treated. Since sentinel sites are a small portion of all schools, it is unlikely that they could be used to catch most instances like this. It might be common for small problems like this to occur within large programs.

Overall assessment of the Mozambique program

Mozambique is one of the countries that SCI has chosen to scale up more quickly than it can with only DFID funds by allocating unrestricted funds. Despite early difficulties, SCI is optimistic about the program. The official in Mozambique has a strong will that has driven the successful delivery of treatments. Data are being reported. Other than the difficulties described above, the people at CNTD have been easy to work with and provide whatever information Dr. Blair requests. In other countries they partner on (Liberia and Zambia), there have not been similar issues.

Monitoring and evaluation in Mozambique

Getting on track with M&E is a priority. SCI and CNTD have made it clear to the government that further support hinges on being able to provide sentinel site data. Baseline prevalence was measured using a different technique than the World Health Organization (WHO) recommends so it cannot be compared to other data.

The government program manager is expected to come to Liverpool next year in part to work on that. It is likely that the country staff needs more resources, and there is a plan to hire a new data manager to help with compiling information in consistent, coherent way.

There has not yet been a coverage survey. SCI expected one, but the previous CNTD program manager did not plan it and this was not communicated early enough to correct. One is expected after this year's MDA.

The Schistosomiasis Consortium for Operational Research and Evaluation (SCORE) is working in Cabo Delgado, Mozambique. Research there is focused on measuring the effectiveness of different MDA schedules.

Mozambique treatment timeline

There has been more than one round of treatment. First, a pilot in one area was done and then scaled up to remaining areas of the country. Later, another large scale treatment round was done. A third round of treatment is scheduled for the next 6 months.

Mozambique treatment strategy

All treatments have been for school-aged children.

In next round, there may be some triple-therapy (three different drugs at the same time), which is uncommon. This would include some adults. WHO states this can be done in areas where the SCH burden is low; it does not advise against this nor advocate for it as there is not enough data. In Zanzibar, the program started with separate treatments and later moved to co-administrating multiple drugs, which has worked fine.

WHO hasn't made a formal statement on when this type of treatment is acceptable. It is up to the country officials to decide what is right; SCI only advises and does not make this decision.

Mozambique spending

CNTD provides SCI with a summary report of costs that includes some breakdowns by activity (e.g. MDA supervision, transportation, training, per diems). There haven't been surprises in looking at these reports.

Program managers' roles

The role of the program manager varies by country depending on the human resources and how much guidance the country requires. If a program is integrated, there are more partners to work with, which complicates the work.

There is a wide variety in experience levels of the government program managers. In some cases (for example, Uganda and Niger), the government program manager understands SCH well and does not require a lot of technical guidance. Others require more guidance from an SCI program manager.

Examples of SCI program manager activities:

- Meet with senior people in the Ministry of Health to advocate for the SCH program,
- Help with reporting to donors,
- Work on the budget,
- Visit warehouses to inspect PZQ, and
- Manage M&E, which is often done through a separate independent entity such as a university instead of by the Ministry of Health.

Uganda is an interesting example. The program had been relatively straightforward to manage. It is now focusing on elimination, which is unknown territory so will require much more guidance. There is a lot of research to do to determine guidelines for how often to treat.

SCI program staff normally have parasitology and epidemiology training. The role is both technical and administrative.

Coverage surveys

Normally, SCI plans to do a coverage survey after the first round of treatment. However, except for Malawi, Cote D'Ivoire and Uganda, this has not happened. After the first round, coverage surveys would probably be roughly every three years unless there are issues that warrant follow up. In follow-ups, surveys may just focus on high and low performing areas.

The issues uncovered in Cote D'Ivoire and Malawi are both examples where the results warrant follow up in order to see if attempts to reach more children have been successful.

Review meetings

Governments generally host annual reviews that SCI attends. The reviews are often set up back to back with planning sessions for the following year. Drug transportation is an issue that comes up at many of these reviews.

These meetings tend not to be very informative for SCI because it normally learns about issues prior to the review through other channels such as trip reports and monthly meetings with program managers.

Financial controls

The standard in SCI (though not CNTD) is to have receipts scanned and coded in the country and then sent back to SCI. Historically, SCI's finance manager has checked all of those receipts. Occasionally, some receipts are missing. This gets caught and the program manager investigates. This has not uncovered any major issues; mostly it turns out that receipts have been in a box and not filed or someone's been out of the office.

Going forward, SCI is adopting a financial risk matrix. This will assign each country a risk score and help SCI monitor high risk countries closely, while spending less time checking receipts for low risk countries. Risk factors might include whether there are financial staff in-country, if DFID had special restrictions in place, or if there are more intermediaries.

MDA

Program managers are normally on the ground for the first MDA in a country. After that, they will go if there is a change in strategy or depending on their judgment of how well things are organized. Once things are going well the program manager doesn't need to be there.

Program managers can learn about issues by looking at treatment reports, e.g. how many reports come back and how quickly. Low reported coverage is a trigger to investigate. SCI program managers normally have a good relationship with country program managers and can discuss possible issues with them.

The government sends observers to schools during the MDA who report on what they see. These reports have been fairly reliable. There's not a large incentive for them to report inaccurately. SCI generally reviews a report of these observations on a country visit, discusses the findings with the country program manager, or receives a consolidated report of the issues that have arisen during the MDA.

Examples of problems in MDA

In 2005 in Tanzania a child died soon after the MDA (which was determined to not be due to the treatment). This was quickly escalated to superiors and handled well by the program staff. However, the family went on the radio and many parents pulled children out of school to avoid treatment. The following year, the program did extra social mobilization before the MDA and was able to achieve high coverage rates.

Dr. Blair was directly involved in this incident. She got an immediate phone call and regular verbal briefings. The program staff largely handled the response, though Dr. Blair contributed to these conversations.

In another case, Malawi had low coverage rates in one MDA. In response, the program heavily invested in social mobilization and had much higher coverage in the next round.

Successful programs

The Malawi program started as a pilot and was expected to scale up slowly, but quickly got to 100% coverage. This may be because programs focused on just SCH and soil-transmitted helminthes (STH) are easier to run than integrated programs. In integrated programs, for example, just one of the drug shipments being delayed pushes everything back.

Uganda has also had success. The program has been going on a long time. Recently, there have been some issues with coverage, which raises questions about treatment fatigue and how to sustain a program over a long time period.

Other successful programs:

- Zanzibar, which is now working towards elimination.
- Cote D'Ivoire has overcome challenges despite a limited team; there is less complexity since SCI is the main organization involved.
- Mozambique, aside from M&E issues. The country has delivered a large number of treatments.

Success in Uganda and Zanzibar has been due to strong leaders and buy-in within the country.

In Ethiopia, everything so far suggests it is working well. For example, there is enthusiasm in the government, and they are doing everything necessary to launch a program.

Challenging programs

Zambia has had internal political issues and lack of strong buy-in. Previously, SCI stopped working there because the government was not providing the support that was needed. More recently, CNTD decided to work in Zambia supporting the government's effort to restart a SCH program as it thought it would be able to successfully manage a program there and was establishing a lymphatic filariasis (LF) program there at the same time. This work is part of the subcontract from SCI under the DFID grant.

Managing the budget has been a challenge in Zambia. Per diem budgets are very high there. The program is broken into 2 ministries, which is unusual. SCI/CNTD are asked to provide support for two offices. Zambia has not yet completed a significant MDA, partly due to this political reshuffle. This means that the cost per treatment is poor because there have been few treatments despite the expenditures.

Other than Zambia, SCI has not considered leaving a country with a program in development. Due to nature of DFID funding, SCI would need a strong case to convince DFID to reallocate funding that is intended for a specific country.

Operating a program in the Democratic Republic of the Congo (DRC) will be challenging. The country does not yet have an NTD department. The intention is to add LF and SCH to existing programs but this has been complex.

Use of additional funding

Budgets for all programs get squeezed, and it would be good if this was not necessary. For example, it is common to cut social mobilization.

Looking forward, Dr. Blair would prioritize additional funding to scale all countries' programs to 100% coverage. For example, Tanzania is being held back by the

complexity of the integrated program. Money is a main factor because the program needs more resources for training. Ethiopia could deliver a lot more treatments than currently budgeted.

GiveWell noted that, in another conversation, Dr. Fenwick, SCI Director, mentioned allocating additional funding to Sudan, Madagascar, and Malawi. Dr. Blair agrees with these selections. Sudan could be really interesting because it is lacking external support to begin a program but seems to have the commitment and enthusiasm. Madagascar is in a similar situation.

Dr. Blair would not choose to stop funding countries where prevalence has been reduced to low levels (for example, Uganda, Rwanda, and Zanzibar). If treatment stops before transmission is halted, prevalence will rebound. However, it is not yet clear that pushing toward elimination, as opposed to maintaining control, is a good use of resources, given that there are still untreated places where morbidity is high.

PZQ donations

WHO independently makes decisions about the allocation of drugs donated by Merck. Merck prefers to be the only supplier in markets where it donates drugs to avoid side effects of other drugs reflecting badly on them. More recently, Merck has acknowledged that this will be unrealistic as donations ramp up and because its donation is limited to treatments for school-aged children yet the WHO guidelines indicate that adults also require treatment in highly endemic areas.

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