**S1. Table Key assumptions of model-based economic evaluations**

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<th>No.</th>
<th>Author (year)</th>
<th>Key assumptions</th>
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| 1   | Collyer et al. (2019) [1] | 1. Immunisation has an immediate effect  
2. Immunisation will decrease the ability for schistosomes to breed in human hosts, as well as the reproductive ability of the female worms  
3. The vaccine does not have a treatment effect on schistosomes already present prior to immunisation  
4. Vaccine decreases the breeding of new worms, and the reproductive ability of female worms both by 90%  
5) Assumption in epidemiological model that the population area has poor sanitation |
| 2   | Lo et al. (2016) [2] | 1. Negative binomial relationship between prevalence and the mean intensity of infection exists (as per published epidemiology studies)  
2. treatment modelled as an immediate reduction in intensity of infection |
2. Individuals susceptible to be re-infected by parasites immediately after treatment  
3. Treatment is an immediate reduction in average parasite burden-  
4. SAC and pre-school children are responsible for two times the relative amount of parasite eggs found in the environment when compared to adults  
5. Treatment coverage was 75%- in line with WHO goals  
6. Medication not donated  
7. Heterogeneity assumed to be constant in the population  
8. Coverage of treatment in population was considered random |
| 4   | De Neve et al. (2018) [4] | 1. Out of pocket costs - 41% of total cost  
2. Infections averted from each intervention are independent of other diseases |
| 5   | Carabin et al. (2000a) [5] | 1. Age distribution assumed equal for both males and females  
2. Treatment decreases worm burden immediately  
3. Coverage at school assumed to be 85% |
| 6   | Ndeffo-Mbah et al. (2013a) [6] | 1. Patients have no natural recovery from FGS.  
2. FGS infection lead to an increase in HIV transmission by a factor that was derived from epidemiological data on HIV-FGS co-infection.  
3. FGS is primarily acquired in childhood.  
4. Girls treated with praziquantel during SAC (5-14 yrs) were less likely to acquire FGS.  
5. Average age of HIV acquisition amongst Zimbabweans is 25  
6. Onset of sexual activity is 15 years |
| 7   | Ndeffo-Mbah et al. (2013b) [7] | 1. Girls treated with praziquantel were less likely to acquire FGS compared to untreated girls  
2. ARV coverage 37% in SSA  
3. Average age of HIV acquisition is 25yrs  
4. At 25 years, if patient acquires HIV, then life expectancy 40 |
2. Perfect mixing'  
3. MDA not donated |
2. Probability of being in a particular health state depends on the action taken at a community level  
3. The Delphi panel experts held prior beliefs about the local population health states, and specific outcomes being experienced by patients  
4. Health states listed are comprehensive and mutually exclusive  
5. Kenyan life expectancy-57 years  
6. The rate of Kenyan government bond= social opportunity cost of capital |
References:


