Ministry of Health

Eswatini
NEGLECTED TROPICAL DISEASES MASTER PLAN
2024-2028

World Health Organization

Preface

Neglected tropical diseases (NTDs) are illnesses that primarily affect the world's poor and have historically received less attention compared to other diseases. These diseases often thrive in developing regions where water quality, sanitation, and access to healthcare are inadequate. Although NTDs are preventable and controllable, they impact an estimated 1 billion people, about one-seventh of the global population. Annually, between 500,000 to 1 million deaths are attributed to these diseases. NTDs are chronic, disfiguring, and disabling conditions that significantly contribute to poverty. They reduce economic productivity in affected adults and hinder the intellectual and physical development of future generations, thereby perpetuating a cycle of poverty. Among the NTDs, several are targeted for elimination as public health problems, including Soil-Transmitted Helminths (STH), Schistosomiasis (SCH), Trachoma, and Lymphatic Filariasis. Additionally, leprosy, Human African Trypanosomiasis, and Onchocerciasis are also targeted for elimination.

Eswatini is not exempt from the growing burden of NTDs. In 2015, the national prevalence of schistosomiasis among school children aged 10 to 14 was 10.25%. In response to this situation, the Ministry of Health (MoH) developed a national master plan aimed at controlling, eliminating, and eradicating NTDs. This master plan is the result of extensive collaboration and consultation among health workers and various sectors that impact NTD control and elimination efforts. The comprehensive multi-year plan includes a situational analysis of NTDs in Eswatini and outlines strategies to prevent, control, eliminate, and interrupt the transmission of these diseases. It serves as a guiding tool for advancing the NTD agenda in Eswatini and fosters coordination, harmonization, and alignment among partners.

Finally, I urge all health workers to utilise this NTD master plan and provide standardised, high-quality care to everyone affected by neglected tropical diseases.

Thank you all.

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Abbreviations and Acronyms

CM	Case management
GDP	Gross Domestic Product
GNP	Gross National Product
IVM	Integrated vector management
LF	Lymphatic filariasis
MDA	Mass drug administration
NTD	Neglected tropical diseases
Oncho	Onchocerciasis
PCT	Preventive chemotherapy
PHC	Primary Health Care
SBCC	Social and behavioural change communication
SCH	Schistosomiasis
STH	Soil-transmitted helminthiasis
SWOT	Strengths, weaknesses, opportunities, and threats
TRA	Trachoma
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
WHO/AFRO	World Health Organization Regional Office for Africa

Key Definitions

Control: Reduction of disease incidence, prevalence, morbidity and/or mortality to a locally acceptable level because of deliberate efforts; continued interventions are required to maintain the reduction. Control may or may not be related to global targets set by WHO.

Elimination (interruption of transmission): Reduction to zero of the incidences of infection caused by a specific pathogen in a defined geographical area, with minimal risk of reintroduction, because of deliberate efforts; continued action to prevent re-establishment of transmission may be required. Documentation of elimination of transmission is called verification.

Elimination as a public health problem: A term related to both infection and disease, defined by the achievement of measurable targets set by WHO in relation to a specific disease. When reached, continued action is required to maintain the targets and/or to advance interruption of transmission. Documentation of elimination as a public health problem is called validation.

Eradication: Permanent reduction to zero of the worldwide incidences of infection caused by a specific pathogen, because of deliberate efforts, with no risk of reintroduction.

Hygiene: Conditions or practices conducive to maintaining health and preventing disability.

Integrated vector management: A rational decision-making process to optimize the use of resources for vector control.

Mass drug administration: Distribution of medicines to the entire population of a given administrative setting (for instance, state, region, province, district, sub-district or village), irrespective of the presence of symptoms or infection; however, exclusion criteria may apply. (In this document, the terms mass drug administration and preventive chemotherapy are used interchangeably.)

Morbidity: Detectable, measurable clinical consequences of infections and diseases that adversely affect the health of individuals. Evidence of morbidity may be overt (such as the presence of blood in the urine, anaemia, chronic pain, or fatigue) or subtle (such as stunted growth, impeded school or work performance or increased susceptibility to other diseases).

Monitoring and evaluation: Processes for improving performance and measuring results to improve management of outputs, outcomes, and impact.

Platform: Structure through which public health programs or interventions are delivered.

Preventive chemotherapy: Large-scale use of medicines, either alone or in combination, in public health interventions. Mass drug administration is one form of preventive chemotherapy; other forms could be limited to specific population groups such as school-aged children and women of childbearing age. (In this document, the terms preventive chemotherapy and mass drug administration are used interchangeably.)

Executive Summary

In accordance with the WHO road map for Neglected Tropical Diseases 2021-2030, one of the milestones raised therein is the integration of all NTDs into a single unit under the Ministries of Health and Eswatini prides itself in that this has been achieved and equally so, the benefits derived from this initiative have brought about insurmountable progress and achievements. The other milestone set out also is the prioritization of the senior NTD Program which led to report directly to top-level management and this again has been achieved hence the spin-offs and aforementioned achievements mentioned above. The third one talks about the integration of STHs into ANC and immunization programs and this again has been achieved as evidenced by the availability of Albendazole in ANC and immunization. It is therefore for that reason that the Ministry with support from the WHO has come up with this master plan.

The purpose of this document is to ensure that this country ultimately has a healthy and productive population. It is envisioned that this shall be made possible by providing the most effective tools and services for NTDs prevention and control through appropriate and modest means thus accelerating the reduction of the disease burden in the populace through control, elimination of the targeted NTDs whose spins offs shall be reflected in improved poverty reduction, productivity and quality of life indicators for the country.

The document further sets out the strategic priorities in the form of pillars that must be achieved to address existing cross-cutting approaches and how to intensify them in a bid to eliminate NTDs as well as create country ownership through coordination and inter-sectoral collaborations to ensure the achievement of the desired results.

This document shall therefore be used as a vehicle for the state in planning for the country's fight against NTDs and further coordinate and strengthen partner support towards the achievement of the intended objectives. It further outlines the targets for the year 2028, being the country's aspired period for the eradication and elimination of these diseases including control. To ensure relevance and reliability, these targets are drawn and, or aligned with the WHO's Thirteenth General Program of Work 2019 -2024 and the globally renowned sustainable development goals. The document also fortifies the need for the integration of the NTDs into the national healthcare system and their inclusion and visibility in the national health development plans.

The master plan encompasses four critical sections; viz; the situational analysis of the country which also covers the national environmental contextual factors that are pivotal in having an in-depth understanding of the country's disease profile, strategic agenda, purpose and goals which also set out the targets and milestones for the endemic NTDs in the country, the operational

framework which details the three fundamental shifts towards tackling NTDs and these is underpinned on the belief that same shall be achieved through increased accountability for impact and process indicators, integration and mainstreaming with other programs and finally budgeting for the impact which provides estimates for the planned activities and justification thereof.

The plan further identifies the NTDs that are earmarked for elimination and control by the country. Leprosy has been singled out as the only one which has been earmarked for complete elimination while rabies, trachoma, lymphatic filariasis, soil-transmitted helminths and schistosomiasis due to their transmission dynamics have been identified as those which could be eliminated as public health problems. The other trench is targeted for control and these are scabies, taeniasis and cysticercosis, food-borne trematodiasis and snake envenoming.

The country desires to ensure that for those requiring chemotherapy, at least 75% of the coverage should be achieved and that skin NTDs strategies are integrated. It is also the country's desire to have 100% access to water supply, sanitation and hygiene services and that all NTDs are integrated, reported and integrated into the national health strategies and our plans.

Introduction

This is a comprehensive five-year Eswatini Neglected Tropical Diseases (NTD) Master Plan 2024-2028 for the control and elimination of targeted NTDs that are relevant in Eswatini. It is an essential strategic document for the government to effectively plan and implement sustainable NTD programmes in collaboration with its national institutes, implementing partners and, donors. It enhances synergies among various NTD initiatives, provides the basis for integrated or linked NTD project plans and includes costing and financing requirements for effective NTD programme performance. The country's NTD Master plan will also form the basis for harmonized implementation and performance monitoring of all NTD interventions.

The NTD Master Plan 2024-2028 governs the prevention, control and, where feasible, elimination of neglected tropical diseases. It aligns with the new NTD Roadmap 'Ending the neglect to attain the Sustainable Development Goals, A road map for neglected tropical diseases 2021–2030'. It aims to be a tool to plan for all relevant NTD programmes in Eritrea and facilitate alignment among partners and stakeholders for joint and complementary support to accelerate progress towards the prevention, control, elimination, and eradication of NTDs.

The Master Plan outlines specific, measurable targets for NTDs endemic in Eswatini, as well as cross-cutting targets aligned with WHO's Thirteenth General Programme of Work 2019-2024, and the SDGs. It also includes the strategies and approaches for achieving these targets, with cross-cutting themes for several diseases, and moves towards the prevention of infections and alleviation of the suffering of people affected by NTDs as well as how this contributes to attaining the SDGs. Progress in implementing planned activities as well as the programme performance and outputs will be monitored regularly and evaluated at appropriate intervals.

NTDs of public health problems in Eswatini include Schistosomiasis (SCH), Leprosy (LEP), Lymphatic filariasis (LF), Rabies, Scabies, Snakebite Envenoming (SBE), Soil Transmitted Helminthiasis (STH) and Trachoma (TRA).

To better address these diseases, the Ministry of Health has established an NTD unit integrated with the national malaria program. The goal is to improve the health and socio-economic status of Swazis by significantly reducing the morbidity, disability and mortality caused by the Neglected Tropical Diseases through an integrated delivery of interventions, at a cost-effective approach, to control and eliminate all targeted NTDs".

The mainstreaming of NTDs into the national health system is critical, therefore the NTD Master Plan should be integrated and reflected in the National Health Sector Strategic Plan. Integration and collaboration of the NTD programme within the NTD and with other programmes including WASH, EDCU etc. is very important.

This document is divided into three main sections: Operating Context, Programmatic Targets and Operational Framework. Figure 2 illustrates the NTD master plan development and revision process.

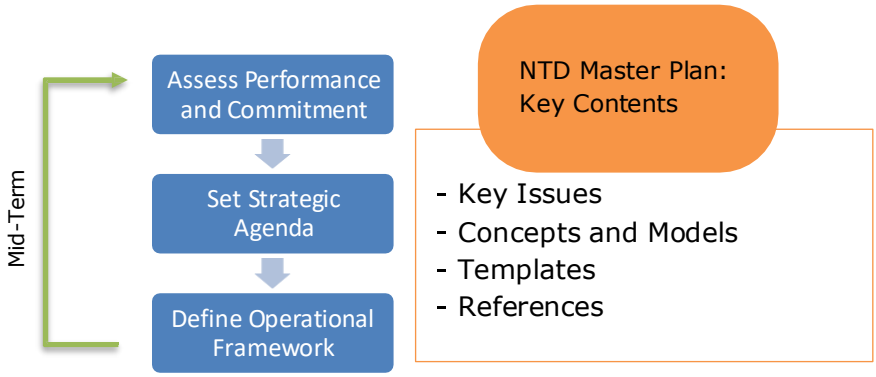


Figure 1: NTD Master Plan Key Contents

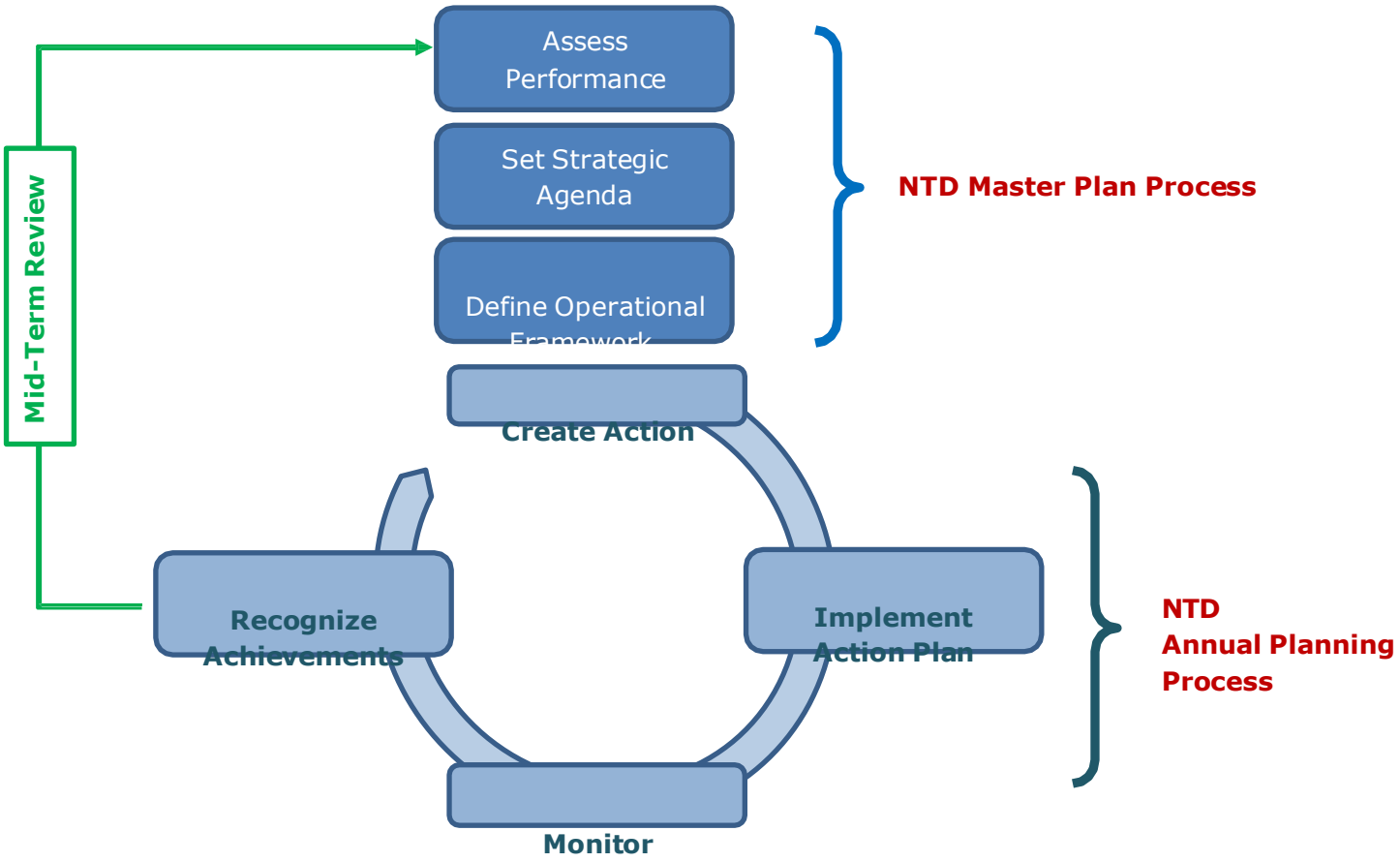


Figure 2: NTD Master Plan and Management cycles

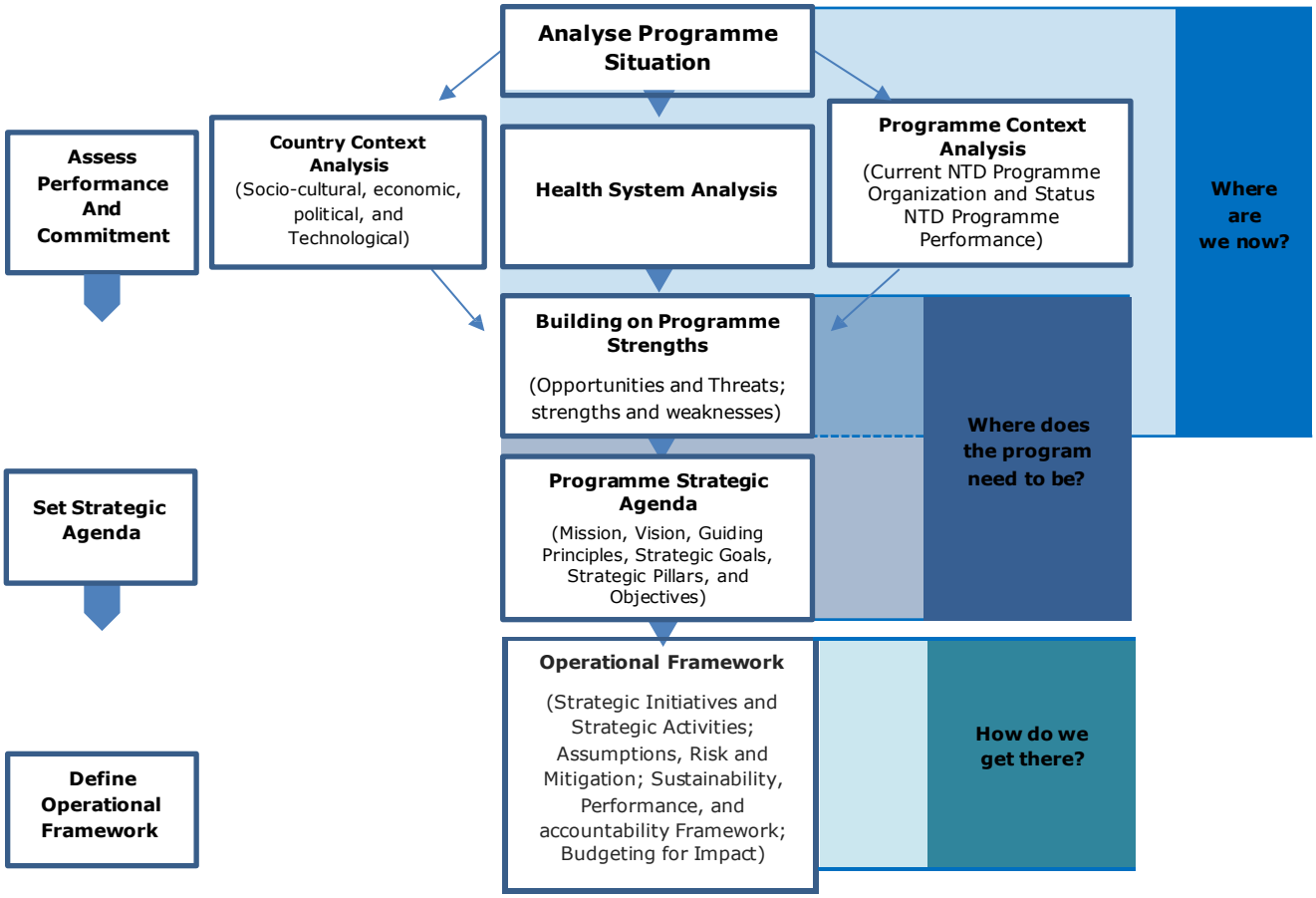


Figure 3: NTD Master Plan Process

Table 1: NTD Master Plan Tools

Key area	Tools
Country Context Analysis	PEST ANALYSIS
Health System Analysis	6 Building Blocks
Programme Context Analysis	Prog. Results and Impact Trends Analysis; Gap Assessment; Structure and Functional Review
Building on Programme Strengths	SWOT Analysis
Programme Strategic Agenda	Mission Statement; Vision, Guiding Principles and Goal Statements; Targets sets; Milestones Charts; 3-level Hierarchy of Objectives. Master Plan Strategic Logic Map
Operational Framework	Operations Planning Tools; Programme Strategic Shifts; Programme Culture and Dual Operating Model; Partnerships Matrix; Coordination Mechanisms chart and TOR; Risk Likelihood and Impact Matrix; Assumption and Risk Register; Risk Mitigation Plan; M&E Framework; Balanced Scorecard; Budgeting Tools

PART 1: NTD SITUATION ANALYSIS

Section 1.1. Re-assessment of National Priorities and the National, Regional and Global NTD Commitments

Neglected Tropical Diseases (NTDs) are a group of diseases that affect the poor and marginalized communities in our societies. They are usually found in the developing world and thrive well in the tropics where the climate and environmental conditions are conducive. In the context of Eswatini, the NTDs portfolio includes bacterial infections that include trachoma and leprosy and those that are caused by helminths such as Soil Transmitted Helminths (STH), (Hookworms, Ascariasis, Trichuriasis), Lymphatic Filariasis, Cysticercosis and Schistosomiasis. Although these NTDs are preventable and can be controlled, an estimated 1 billion people, which is one-seventh of the world's population, are affected by these NTDs. About 500,000 to 1 million deaths occur annually due to NTDs. NTDs are chronic, disfiguring and disabling conditions. They are among the leading perpetrators of poverty as they significantly diminish economic productivity in affected adults and the intellectual and physical development of the next generation, thus reinforcing a cycle of poverty.

Since the launch of the first NTD Road map in 2012, significant progress has been made in the prevention, control, elimination, and eradication of NTDs. For example, today, 600 million fewer people require interventions against several NTDs as compared to 2010, and 42 countries, territories and areas have eliminated at least one disease. In addition, Dracunculiasis is on the verge of eradication with only 54 human cases reported globally; elimination of LF (17 countries) and trachoma (10 countries) as public health problems have been achieved, and onchocerciasis has been eliminated in four countries. The annual number of cases of human African trypanosomiasis (HAT) has fallen to fewer than 1000 cases (from more than 7000 in 2012) and the number of new leprosy cases reported globally has continued to decline.

Summary of the NTDs present in the country.

NTDs that are endemic or suspected to be endemic in Eswatini categorized by disease control or elimination status are shown in Table 1.1 below.

Table 1.1: NTDs that are endemic or suspected to be endemic in Eswatini categorized by disease control or elimination status.

Table 2: Endemic NTDs in Eswatini

Targeted for elimination (interruption of transmission)	Targeted for elimination as a public health importance	Targeted for control
1. Leprosy	1. Rabies	1. Scabies
	2. Trachoma	2. Taeniasis and cysticercosis
	3. Lymphatic Filariasis	3. Foodborne Trematodiasis
	4. Soil-Transmitted Helminths	4. Snakebite envenoming
	5. Schistosomiasis	

National development goals

Goal

The policy envisages as its goal the attainment of the highest possible level of health and well-being for all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship consequently. This would be achieved through increasing access, improving quality, and lowering the cost of healthcare delivery. The policy recognizes the pivotal importance of Sustainable Development Goals (SDGs). An indicative list of time-bound quantitative goals aligned to ongoing national efforts as well as the global strategic directions is detailed at the end of this section.

Objectives

Eswatini's National Development Strategy, Vision 2022, defines its aspiration to be in the "top 10 percent of the medium human development group of countries" and commitment to address issues of poverty and access to quality health care, gender equity, and social integration, emphasizing technology use and innovation to help reach its vision (World Bank 2020). The National Health's main Objective is to improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with the focus on quality.

Progressively achieve Universal Health Coverage

A. Assuring availability of free, comprehensive primary health care services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population. The Policy also envisages optimum use of existing manpower and infrastructure as available in the health sector and advocates collaboration with non -government sector on a pro-bono basis for delivery of health care services linked to a health card to enable every family to have access to a doctor of their choice from amongst those volunteering their services.

B. Ensuring improved access and affordability, of quality secondary and tertiary care services through a combination of public hospitals and well-measured strategic purchasing of services in healthcare deficit areas, from private care providers, especially the not-for-profit providers.

C. Achieving a significant reduction in out-of-pocket expenditure due to health care costs and achieving a reduction in the proportion of households experiencing catastrophic health expenditures and consequent impoverishment.

Reinforcing trust in the Public Health Care System:

Strengthening the trust of the common man in the public health care system by making it predictable, efficient, patient-centric, affordable and effective, with a comprehensive package of services and products that meet the immediate health care needs of most people.

Aligning the growth of the private healthcare sector with public health goals:

Influence the operation and growth of the private healthcare sector and medical technologies to ensure alignment with public health goals. Enable private sector contribution to making health care systems more effective, efficient, rational, safe, affordable and ethical. Strategic purchasing by the Government to fill critical gaps in public health facilities would create a demand for the private healthcare sector, in alignment with the public health goals.

Policy objectives related to the health sector under the National Plan of Action are as follows:

- Develop appropriate organizational structures at the national, regional and health facility level to improve management, coordination, planning, monitoring and evaluation of health services.
- Improve and expand comprehensive primary and reproductive health care programmes.
- Improve the health infrastructure and delivery system in the Kingdom.
- Improve cooperation with donor agencies as well as NGOs involved in the delivery of health care services.
- Strengthen the fight against the HIV/AIDS pandemic.
- Intensify the mobilization of "Health for All" through nationwide health education campaigns.

Global, regional, and national commitments on NTDs

The Regional Strategy on Neglected Tropical Diseases in the WHO African Region (document afr/rc63/10); AFR/RC63/R6, Sept. 2013

The Regional Committee,

Having examined the document entitled "Regional Strategy on Neglected Tropical Diseases (NTD) in the WHO African Region" and the related Regional NTD strategic plan 2014-2020.

Recalling the commitment that ministers of health of Member States of the African Region made during the Fifty-ninth session of the Regional Committee, the sixth Conference of African Union Ministers of Health, as well as resolution WHA 66.12 on scaling up proven interventions against the major NTDs.

Cognizant that the African Region bears a very high burden of neglected tropical diseases (NTDs) which pose a threat especially to the poorest and most marginalized communities and hamper socioeconomic development.

Urged member states:

(a) to provide leadership and ensure ownership in establishing and strengthening integrated national NTD programmes and national NTD coordination mechanisms, while forging multi-sectoral collaboration to address functional gaps that constrain programme interventions and promoting linkages between NTDs and other health programmes.

(b) to strengthen planning and increase national financial commitments to achieving NTD targets and goals by including national NTD multi-year budgets into the national health sector budget and promote the inclusion of NTDs in the post-2015 national development agenda.

(c) to rapidly scale up interventions and strengthen health systems to tackle NTDs at all levels and ensure regular monitoring and tracking of progress.

(d) to expand investment in research and development of medical products and the strategies to tackle NTDs.

It also urged Partners:

to mobilize increased resources including medicines, funds and logistics and confirm long-term commitments to country NTD programmes, aligning their support with national priorities and NTD coordination mechanisms and structures.

The 66.12th World Health Assembly Resolution: WHA66.12, 2013

Recognizing that increased national and international investments in the prevention and control of neglected tropical diseases have succeeded in improving health and social well-being in many countries,

Acknowledging the linkages between, and mutual supportiveness of, control and elimination of neglected tropical diseases and the global strategy and plan of action on public health, innovation and intellectual property.

Acknowledging also, the expansion of activities to prevent and control neglected tropical diseases will need adequately resourced national programmes functioning within effective health, education and other sectors to provide for an uninterrupted supply and delivery of quality-assured commodities and services, among other key observations.

Recognizing also the diversity of neglected tropical diseases, their causative agents and relevant vectors and intermediate hosts, their epidemic potential (such as dengue, Chagas disease, human rabies of canine origin and leishmaniasis), and their morbidity, mortality and associated stigmatization urged member states to ensure continued country ownership of programmes for neglected tropical disease prevention, control, elimination and eradication to further strengthen the disease surveillance system, especially on neglected tropical diseases targeted for eradication to expand and implement, as appropriate, interventions against neglected tropical diseases to reach the targets agreed upon in the Global Plan to Combat Neglected Tropical Diseases 2008–2015, as set out in WHO's roadmap for accelerating work to overcome the global impact of neglected tropical diseases and noting the London Declaration on Neglected Tropical Diseases by ensuring that resources match national requirements and flow sustainably as a result of thorough planning and costing of prevention and control activities and detailed analysis of associated expenditures; enabling improvement of the management of the supply chain, in particular through forecasting, timely procurement of quality-assured goods, improved stock-management systems, and facilitating importation and customs clearance; integrating neglected tropical disease control programmes into primary health care services and vaccination campaigns, or into existing programmes where feasible, to achieve greater coverage and reduce operational costs; ensuring appropriate management and implementation through the development, sustenance and supervision of a cadre of skilled staff (including other sectors than health) at national, district and community levels;

The 2021-2030 NTD Road Map (2020)

The road map for neglected tropical diseases 2021–2030 is WHO's second proposal for preventing, controlling, eliminating and eradicating neglected tropical diseases.

The WHO Global Roadmap for Neglected Tropical Diseases 2021-2030 proposed three strategic shifts that will facilitate accelerated progress towards control, elimination (interruption of transmission, and where possible eradication of NTDs namely, i) accelerating programmatic action with a focus on impact rather than progress measures; ii) intensifying cross-cutting approaches and iii) changing operating models and culture to facilitate country ownership for NTD control.

The Seventy-Third World Health Assembly, WHA73; 13 November 2020

WHA73, having considered the report on neglected tropical diseases, and recalling resolution WHA66.12 (2013) on neglected tropical diseases, and WHO's Road map for accelerating work to overcome the global impact of neglected tropical diseases (2012–2020), and Member States' commitment to Sustainable Development Goal target 3.3, decided:

to endorse, and urge Member States to implement, the new road map for neglected tropical diseases 2021–2030, "Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030".

to request the Director-General to advocate for, and provide technical assistance and guidance to Member States and partners in the implementation of, the new road map for neglected tropical diseases 2021–2030 towards reaching Sustainable Development Goal target 3.3

The London Declaration on NTDs (2012)

In 2012, partners including pharmaceutical companies, donors, endemic countries and non-governmental organizations committed themselves to: sustain, expand and extend programmes that ensured the necessary supply of drugs and other interventions to help eradicate guinea worm disease and help to eliminate by 2020, lymphatic filariasis, leprosy, sleeping sickness (Human African trypanosomiasis) and blinding trachoma.

Sustain, expand and extend drug access programmes to ensure the necessary supply of drugs and other interventions by 2020 to control schistosomiasis, chagas disease, soil transmitted helminthiasis, visceral leishmaniasis, and river blindness (leishmaniasis), Advance Research and Development to through partnership and provision of funding to find next generation treatment and intervention of for neglected tropical diseases.

To enhance collaboration and coordination on NTDs at national and international level through public and private multilateral organizations to work more efficiently and effectively together.

Enable adequate funding with endemic countries to implement NTD programmes necessary to achieve these goals, supported by strong and committed health systems at national level.

Provide technical support and tools and resources to support NTD endemic countries to evaluate and monitor NTD programmes.

The Addis Ababa NTD Commitment (2014)

The assembled Ministers of Health and Heads of Delegations used their unique voice to buttress the efforts of many others who have committed to fighting NTDs and combating global poverty. Whereas Ministers of endemic countries had endorsed and committed to achieving the WHO Roadmap goals through passage of the WHA 66.12, and further committed to:

- Work to increase our domestic contribution to the implementation of NTD programs through the expansion of government, community and private sector commitments,
- Promote a multi-sectoral approach in the implementation of NTD program goals that improve national coordination, facilitates partner collaboration, and improves the management of technical and financial contributions,
- Ensure the adoption of both long-range strategic and annual implementation plans which are grounded by appropriate goals and detailed costs that drive and support NTD programs to achieve global targets,
- Report and use program data in a timely fashion to follow progress against program goals and to inform program planning and execution,
- Ensure that the implementation of NTD programs contributes to the strengthening the overall health system and vice versa.

The place of NTDs in the national health plan and the commitment of national authorities to the control, elimination and eradication of NTDs.

Eswatini Government through the Ministry of Health has recognized NTDs as a problem in the country, NTDs indicators forms part of the National Health Priority Indicators as per the HSP block. Like any other Eswatini had not yet managed to allocate domestic funding Annually specifically for the NTD programme. MDA medicines have been donated by the World Health Organization resulting in the country having been able to conduct one round of MDA for schistosomiasis and another round of MDA for STH respectively. The programme falls under the Division of Epidemiology and Disease Control however, it does not have a full time Directorate, a sign showing the minimal recognition of the programme.

Purpose of the master plan

The Eswatini NTD Master Plan (2024-2028) governs the prevention, control and, where feasible, elimination and eradication of neglected tropical diseases endemic in Eswatini. It aligns with the NTD Roadmap '*Ending the neglect to attain the Sustainable Development Goals A road map for neglected tropical diseases 2021–2030*. The aim of this Master Plan is to be a tool for the government of Eswatini to plan for all NTD programmes in the country which facilitate alignment among partners and stakeholders for a joint and complementary support to this country and to accelerate progress towards the prevention, control, elimination, and eradication of all NTDs in Eswatini. It provides all partners working on NTDs in Eswatini with a harmonized tool that will facilitate joint support to this country.

The Master Plan outlines specific, measurable targets for 2028 for the eradication, elimination and control of all NTDs endemic in Eswatini, as well as cross-cutting targets aligned with WHO's Thirteenth General Programme of Work 2019-2024, and the SDGs. It includes the strategies and approaches for achieving these targets, with cross-cutting themes for several diseases, and moves towards the prevention of infections and alleviation of the suffering of people affected by NTDs endemic in Eswatini, as well as how this contributes to attaining the SDGs.

Progress in implementing planned activities as well as the programme performance and outputs will be monitored regularly and evaluated at appropriate intervals by the government. The strategic plan will be the framework for coordination, harmonization, and alignment of both central and sub-national governments, as well as partners. Therefore, consensus on the content will enhance the commitment and accountability of all stakeholders for success in resource mobilization. The integration of NTDs into the national health system is critical, therefore this NTD Master Plan will be integrated and reflected into the national health development plans.

Summary description of the Parts of the Master Plan

The Master Plan comprises of four key sections: -

1. **NTD Situation Analysis**: This describes the environment within which the NTD programme will be developed and implemented in Eswatini, including the national environmental and contextual factors that are critical in understanding the distribution of NTDs and their control.
2. **Strategic Agenda, Purpose and Goals:** which provides an overview of the targets and milestones for all the NTDs that are endemic in the country, determined through a consultative process.
3. **Operational framework:** which describes how the three fundamental shifts in the approach to tackling NTDs will be realized specifically through; i.) increased accountability for impact by using impact indicators instead of process indicators; a move away from siloed, disease-specific programmes by mainstreaming programmes into national health systems and intensifying cross-cutting approaches centred on the needs of people and communities; and a change in operating models and culture to facilitate greater ownership of programmes by countries.
4. **Budgeting for Impact:** provides budgetary estimates and justifications for the included activities to be implemented.

Section 1.2. National Context Analysis

1.2.1 Country Analysis

The Kingdom of Eswatini, formerly Eswatini (officially renamed in 2018) is an independent Monarchy found in the southeastern part of Africa GPS coordinates 26°30′S 31°30′E. The beautiful kingdom is approximately 17, 364 km^2 in size. Eswatini is a landlocked country, sharing

her borders with South Africa to the west and Mozambique to the east. The county is divided into four ecological and topographic zones` namely: the highveld, Middleveld, lowveld and the Lubombo plateau. Eswatini is further divided into 55 constituencies known as Tinkhundla with 360 chiefdoms. It has varying landscapes, with a subtropical climate composed of wet summers and cool winters. According to the 2017 Population and Housing Census, Eswatini's population stood at 1,093,238. The country has two capitals, the Royal and Legislative capital located in Lobamba and the Administrative capital of Eswatini located in Mbabane. Eswatini is a constitutional monarchy with two spheres of Government: the national government and the local government. Figure 3.1 shows the four regions that constitute the main geographical regions of the Kingdom.

Figure 3.1: Geo-Political map of Eswatini (source: Review and update of the State of the Environment Report – Restoring the Environment for Climate Resilient Economic Recovery (2020)

Demographic Data

The 2017 Population and Housing Census indicate that current population stood at 1,093,238 in 2017, comprising of 531,111 males (48.6 percent) and 562,127 females (51.4 percent).

Table 1.2: Demographic Data

	1960	2007	2017	2050
Population Total (thousands)	279	1,018	1,093	1,376+
Average Population Growth Rate for period (%)	3.5	0.9	0.7	0.7+
Male to Female Ratio (number of males for every 100 females)	91.4	89.6	94.5	-
Population Proportions By Age Groups (%)				
Age 0 -14	45.1*	39.5	35.6	27.5*
Age 15 - 34	31.9*	37.7	37.7	35.4*
Age 35 - 64	20.1*	19.1	22.2	32.8*
Age 65+	2.9*	3.7	4.5	4.3*
Total Fertility Rate (number of children per woman)	6.7*	4.0	3.3	2.1*
Dependency Ratios (number of dependents to the number of working age population)	0.92*	0.71	0.67	0.47*
Urban Population (% of total population)	3.9*	22.1	23.8	30.7+
Net Migration Rate (per 1,000 people)	-7.11*	-1.18*	-1.83*	-

*Source: CSO 2017 & 2007 Population and Housing Census; *UNFPA & UN Population Division; + Assumed 2017 period growth rates*

Geography and Climate

Eswatini is a small landlocked country in Southern Africa bordered by South Africa in the north, west, and south and by Mozambique in the east. It lies between latitude 25^0 S and 28^0 S and longitudes 31^0 E and 32^0 E, spanning approximately 17,364 km^2. Despite its small size, the land and climate are diverse, the country is divided into four agro-ecological zones: The Highveld ranges from 900m to 1400m with annual average temperatures of 17^0 C, the Middleveld ranges from 400m to 800m with annual average temperatures of 20^0 C, the Lowveld ranges from 200m to 400m with annual average temperatures of 22^0 C, and the Lubombo Plateau ranges from 250m to 600m with annual average temperatures of 21^0 C. The ecological zones have diverse climate conditions ranging from sub-humid and temperate in the Highveld to semi-arid and warm in the Lowveld. About 10 percent of the land is arable and the country holds several natural resources including coal, iron ore and water.

Political:

Swaziland is a small landlocked country in southern Africa, neighbouring South Africa, and Mozambique. Administratively, the country is divided into four regions, namely: Hhohho, Manzini, Lubombo and Shiselweni; and further divided into 55 local authorities (Tinkhundla) and 365 chiefdoms. It has a population of 1,018,448, of whom 53% are women (MOEPD, 2007c). The King is head of state and appoints the Prime Minister as chairperson of the Cabinet and heads of government (AfDB, 2013). Swaziland is a Monarchy whose current Head of State is His Majesty King Mswati III, who ascended to the throne on the 25th of April 1986. Both the country's political and legal systems can be described as dual in that they feature the simultaneous operation of traditional institutions and Western methods of modern governance and Roman-Dutch common Law. The Constitution of Swaziland Act No.001/2005 came into force on 26 July 2005. The Constitution is the supreme law of the land. The Constitution provides for three organs or arms of government, that is the Executive, a bicameral Legislature, and the Judiciary. Each of these organs is independent from other arms.

The Electoral System

Swaziland practices a Tinkhundla–based electoral system of government. The Tinkhundla system is a democratic participatory system which emphasizes the devolution of power from central government to Tinkhundla (constituencies) areas and individual merit as a basis for election or appointment to public office. Eswatini has not experienced any civil war (unrest). This makes the country a suitable environment for uninterrupted implementation of successful NTD control, elimination, and eradication programmers. According to section 79 of the Constitution of Swaziland, the system of Government is democratic and participatory based on the Tinkhundla. The system emphasizes the devolution of state power from central government to Tinkhundla while individual merit is a basis for election and appointment into public office.

In general, Tinkhundla stimulates community development at the grassroots level, coordinating and promoting a good relationship between Government and Non-Governmental Organizations (NGOs) working at the Tinkhundla level. They further provide a link between communities and government as well as other development agents to ensure the responsiveness of all national policies to the needs of the people. In the process, they create harmony among all agents providing services within that Inkhundla.

The Ministry of Tinkhundla Administration and Development has a mandate to facilitate the management of regional development and promote service delivery at the Tinkhundla and Chiefdoms levels. Tinkhundla is the foundation for the bottom-up development planning process and the delivery of local services in partnership with the central government. A major area of

focus in the process is development; implementation, monitoring and evaluation of evidence-based integrated development plans funded by development grants and central government budget where applicable. The Ministry also has a mandate to bring about improvements in the performance and effectiveness of the administration and management of the Regions, Tinkhundla Committees, and chiefdoms.

Economics:

Eswatini is classified as a lower middle-income country; however, income inequality is high, with a stagnant Gini coefficient estimated at 0.49 between 2010 and 2017. Economic challenges persist with 58.9% of the population living below the national poverty line. Use of international poverty lines also supports the persistence of poverty: the $1.90/person/day (2011 purchasing power parity (PPP)) international poverty rate has hovered around 30% since 2016, estimated at 29.7% in 2020. This rises to 52.7% when the 2011 PPP $3.20 per person per day poverty line for lower middle-income countries is used (World Bank, 2021). The COVID-19 pandemic threatens to perpetuate the historically high poverty levels. Projections indicate a stagnation in poverty rates in the medium term due to reduction in employment incomes and remittances because of the COVID19 pandemic. The 2021 GDP growth projections remain uncertain at 2.7%, recovering from a 2.4% COVID-19 induced recession in 2020 (Eswatini Government Budget Speech, 2021). Economic recovery remains uncertain and depends on the evolution of the COVID-19 pandemic, the rollout of vaccines and the pace of recovery of the global and regional economies particularly that of South Africa and the Southern Africa Customs Union (SACU). In response to the impact of the pandemic the government launched a private sector led Post-COVID19 Economic Recovery Plan in August 2020 (PEPFAR. 2021).

The Kingdom has close economic links to South Africa on which it depends for about 85 percent of its imports and 60 percent of its exports. Eswatini is a member of the Common Monetary Area with Lesotho, Namibia, and South Africa, under which the Eswatini lilangeni (SZL) is pegged at par to the South African rand. Eswatini's close economic ties to South Africa mean about 85% of its imports and about 60% of its exports depend on its much larger neighbor. It is a member of the Common Monetary Area (CMA), with Lesotho, Namibia, and South Africa. Under the CMA, the Eswatini lilangeni (the domestic currency) is pegged to the South African rand, which is also legal tender in the country.

The economy had a strong rebound in 2021, with real GDP growth estimated at 7.9%, up from a 1.6% contraction in 2020. The easing of lockdown measures in 2021 supported export-oriented sectors, as well as the robust recovery in external demand in key destination markets. Though political unrest in June/July 2021 resulted in the destruction of physical assets, theft of inventory, and constrained operational hours, its impact on production was partly mitigated by a Reconstruction Fund, set up by the government to cushion businesses from lasting effects of the damage.

Inflationary pressures picked up during 2022Q2, mainly driven by food and transport costs and a depreciating local currency. Annual inflation averaged 4.2% in 2022Q2, higher than 3.2% in 2022Q1 and 3.7% in 2021Q2; it continued an upward trend as it increased to 5.8% in August 2022 from 5.4% in July 2022. Transport and food contributed to over half of annual inflation, and the exchange rate depreciated by about 6% during first half of 2022. In response to these high inflationary pressures, the Central Bank increased the discount/repo rate by a cumulative 200 basis points between January and September 2022 (from 4% at the beginning of the year). The fiscal deficit was contained within budget limits—at 4.6% of GDP—as the government implemented expenditure cuts, including public investment, in line with its three-year fiscal adjustment plan. The reduction in the fiscal deficit took place in the context of lower overall revenues amid lower South African Customs Union (SACU) revenues. However, public debt increased as the government accessed loans to finance the budget deficit.

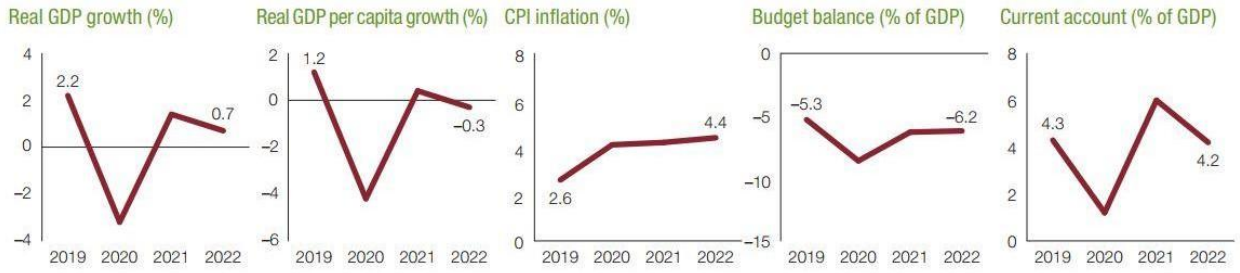
Real GDP growth is projected to slow to 1.1% in 2022, reflecting implementation of the government's three-year fiscal adjustment program and inflationary pressures from the war in Ukraine. Annual average inflation is projected to increase to 4.8% in 2022 from 3.7% in 2021, driven by high food and fuel prices. The current account balance is projected to turn into a deficit in 2022—the first time since the 2010/11 fiscal crisis, reflecting declining SACU revenues and rising imports due to higher fuel/food costs arising from the war.

The economy of the country is based on agriculture, mining, food processing, and manufacturing of clothing and light consumer goods. The country is heavily dependent on South Africa from which it receives more than 90% of its imports, and exports 60% of its produce. The level of economic growth has been largely dependent on fluctuations in the performance of the agricultural sector, which has in turn been impacted by erratic climatic conditions and changes in prices of agriculture products in the world market.

Outlook and risks

The economy is projected to grow by 1.4% in 2021, underpinned by a modest recovery in all sectors. Agriculture, manufacturing, and construction are expected to lend greater impetus to recovery, while an expected strengthening of domestic demand will reignite services growth. Planned reforms to make it easier to do business, along with the clearance of domestic arrears, should stimulate private investment. Risks to recovery include a longer pandemic, inadequate progress on a COVID–19 vaccine, and external developments. Medium-term growth is expected to be tepid, weighed down by accelerated fiscal consolidation and a decline in projected Southern African Customs Union (SACU) receipts. As a result, the fiscal deficit will slightly decline but remain elevated. According to the International Monetary Fund's 2020 Debt Sustainability Analysis, if eSwatini implements its 2021–23 fiscal adjustment plan (totaling 6.5% of GDP), public debt will rise to about 50% of GDP in 2021, reach a high of 53% of GDP in 2024, then gradually decline. The current account surplus and international reserves are expected to improve

as export demand recovers. Upside inflation risks include higher food prices and increases in water and electricity tariffs. The projected appreciation of the lilangeni/rand to near prepandemic levels is expected to minimize the pass-through effect of oil price increases on inflation (African Economic Outlook. 2022.)



Source: Data are as of December 2020 and are from domestic authorities; figures for 2020 are estimates and figures for 2021 and 2022 are projections by the African Economic Outlook team. Data on the budget balance correspond to eSwatini's fiscal year, which runs from April 1 to March 31.

Figure 3.2: Economic Growth Rates
Source: African Economic Outlook (AEO) 2022

Social:

Eswatini lifestyle and culture

The people of Eswatini actively maintain and preserve an extraordinary cultural heritage that is likely unrivaled in Africa. Visitors can get a better sense of traditional African culture here than almost anywhere else in the region, and what they see, including spectacular festivals, has not been resurrected for the tourist dollar but is the real thing. The famous Umhlanga (Reed Dance) and Incwala ceremonies involve tens of thousands of Swazi people and draw visitors from all over the world. Traditional attire, ceremonies, and dancing, however, can be found throughout the country at any time of year. Swazis are an extremely proud and friendly people. There are several museums and heritage sites in the country that serve to exhibit the country's history and traditions, such as Umsamo Wesive, which was built in 1972 and sits just behind parliament in Lobamba, the country's traditional capital. Other historical sites include the Bulembu Mining Museum, the new Sugar Cane Museum, and Execution Rock, to name a few.

The people of Eswatini are spiritual with the country being a Christian state. There is a belief in ancestors and traditional healers that influences the attitudes and health-seeking behaviors of the populace. These practices can prove problematic for conditions that require prompt action for good outcomes e.g., snakebites. One study showed that there were strong beliefs that snakes were of supernatural origin and thus required supernatural intervention.

Eswatini Population growth and demographics, family size/ structure, migration, lifestyle trends,

This briefly presents the findings of the 2017 Population and Housing Census which was conducted in September 2017.

Population Size

The estimated population projections of Eswatini from 2022 are 1,174,014 as compared to 1,093,238 enumerated in the 2017 Population and Housing Census. Eswatini population growth rate is 1.2% per annum (2017 - 2038 POPULATION PROJECTION). 51.3% of those enumerated in 2017 were found to be female while the balance was 48.7% (2017)

Population Growth

The population increased from 1,018,449 in 2007 to 1,093,238 in 2017, representing a 7.3 percent increase between the two censuses. Between 2007 and 2017, the annual population growth rate is estimated to be 0.73 percent. Manzini is home to 32.6 percent of the country's population, while Hhohho is home to 29.3 percent. Lubombo had 19.4 percent of the population, while Shiselweni had 18.7 percent. During the period 2007-2017, the Hhohho region experienced the highest growth of 1.3 percent, while Shiselweni experienced the lowest growth of -0.2 percent. Manzini is both a commercial and industrial hub for the country, so rapid population growth was anticipated. Hhohho and Lubombo had 1.1% and 0.2%, respectively. The male-to-female ratio increased from 90 in 2007 to 94 in 2017.

Average Household Size

The ratio of the total population to the total number of households is represented by the household size. In 2017, a total of 272824 household types were registered. 97.91% of these were regular households, which are defined as a person or group of people who live together and share meals (eat from the same pot), with the sharing of meals being the most important criterion in identifying a household in a homestead. Other types of households include collective households, which are defined as a large group of people who share common facilities such as a kitchen, toilet, lounge, and dormitories. This came in second at 2.01%, with homeless households accounting for only 0.03% of all household types.

The average size of a regular household has decreased from 4.7 in 2007 to 4.0 in 2017. Manzini had the top two tinkhundla with the highest distribution, Kwaluseni and Manzini North, with 24041 and 11695 households, respectively. Mbabane east of Hhohho was ranked third in the

country, with 11523 regular households. (Census Eswatini 2017) This may be due to the fact of the vicinity of these area to the economic and administrative activities found in the area found within these tinkhundla. The bottom three in terms of household distribution include Mangcongco with 889, Kubuta with 1224 and Nkwene with 1247.

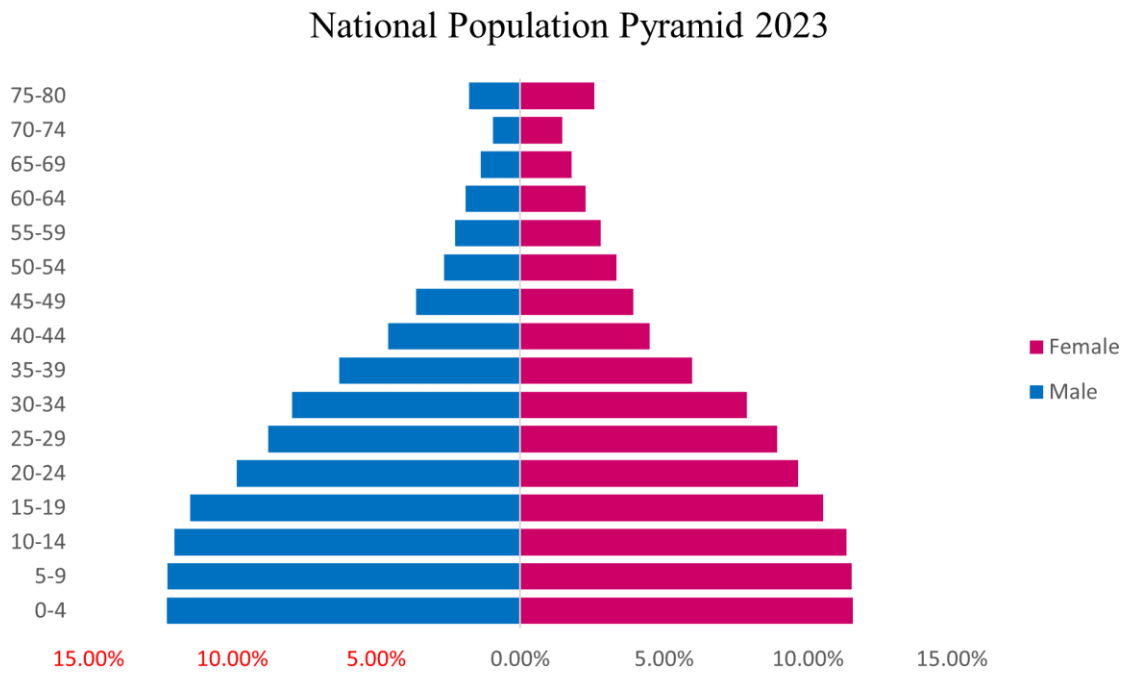


Figure 3.3: Eswatini National population pyramid (source : Census Eswatini 2024)

Migration

The current net migration rate for Eswatini in 2022 is -5.152 per 1000 population, a 9.76% decline from 2021. The net migration rate for Eswatini in 2021 was -5.709 per 1000 population, an 8.87% decline from 2020. The net migration rate for Eswatini in 2020 was -6.265 per 1000 population, an 8.16% decline from 2019. The net migration rate for Eswatini in 2019 was -6.822 per 1000 population, a 7.54% decline from

(Sources : https://www.macrotrends.net/countries/SWZ/eswatini/immigration-statistics)

Technological:

Eswatini has continued to strengthen liberalization of the telecommunications industry. The country has three telecommunications service providers with over 80% mobile market penetration. Mobile cellular subscriptions increased from 82.2 per 100 people in 2014 to 93.5 in 2017 while the number of fixed telephone subscriptions declined from 4.1per 100 people in 2014 to 3.6in

2017. The proportion of the population using the internet increased from 26.2% in 2014 to 47% in 2017. Government plans to further roll out broadband networks to schools and hospitals, as well as to liberalize broadband access. However, the AIDI index on ICT stands at a low 18.32.

On the other hand, the Ministry of health e-health strategy provides a fresh impetus for improving service delivery and achieving health outcomes for all people across all levels: Central, district, facility, and community. The strategy influences the adoption of recent technologies which include health concepts as well as digitisation of all data collection processes. The country's client management information system (CMIS) is an electronic health records EHR system that improves patient care by improving data quality and access, reducing duplicated cases within the system, and improving patient flow and wait times within the clinic. A logistics management information system (LMIS) is an organized system for collecting, processing, reporting, and using health product data gathered across all levels of the health system. Effective supply chains depend on functional LMIS. LMIS data is essential for quantification processes and for planning distribution along the supply chain, avoiding overstocks and stock-outs.

Eswatini's electronic medical record system, known as the Client Management Information System (CMIS), is available in less than half of facilities (48 percent) and does not cover, or inadequately covers, all health conditions. In addition to scale up of the CMIS, technical assistance (TA) in capacity building in data analytics and science to enable the efficient utilization of the available data and in the maintenance of hardware, software, and data warehousing, is required. • In addition to the CMIS, other digital health interventions are not used extensively in Eswatini, for example, for client communication, clinical case management, and health care provider decision support and referral coordination (World Bank Report 2020).

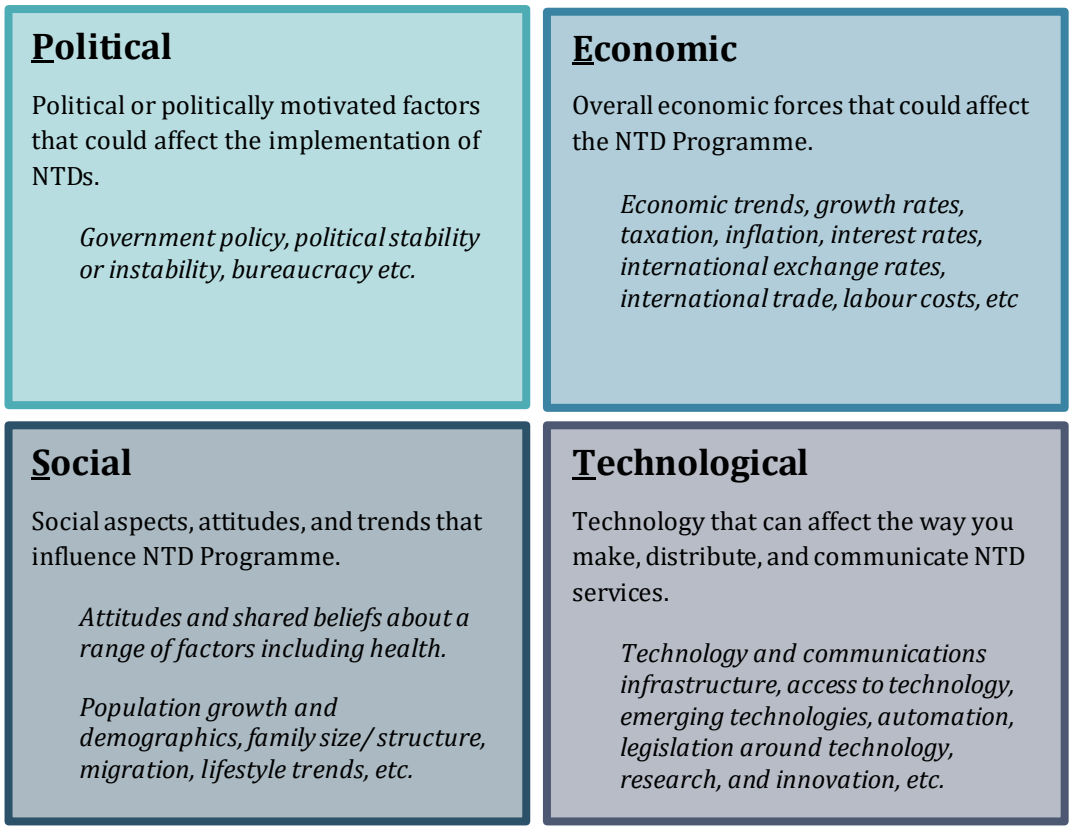


Figure 4: The PEST analysis

1.2.2. Health Systems Analysis

According to the WHO 2014 World Health Statistics, the health status in Eswatini is below expectation, with life expectancy at birth estimated at only 54 years (52 years for males, and 55 years for females). This level is very low, as compared to other middle-income countries where the life expectancy (at birth) on average ranges from 63.8 – 72 years for males, and 67.9 – 76.2 years for females. The rate is even lower than that for low-income countries (60.2 years for males, and 63.1 years for females). The rate is however higher than it was in the year 2000, when it had dropped to 48 years (48 and 49 years for males and females respectively), though not yet at the level of 1990 where it was at 61 years (62 and 61 years for males and females respectively).

All age groups have experienced significant increases in mortality in the preceding 20 years. However, apart from the adult mortality rate all the other age groups have been experiencing reducing mortality in the past 10 years. At present, though, mortality rates for all age groups are still higher than they were in the year 1990. The increase in overall mortality and reduction in life expectancy has been attributed to the HIV/AIDS epidemic that has ravaged the country.

Eswatini Health system goals and priorities

VISION

A healthy and productive Swazi population that lives longer, fulfilling, and responsible lives.

MISSION To build an efficient, equitable, client-centered health system for accelerated attainment of the highest standard of health for all people in Eswatini.

OBJECTIVES

- Promote health and prevent diseases.
- Reduce morbidity and mortality.
- Strengthen health systems capacity and performance.
- Improve access to essential affordable and quality health services.

Table 2: Six Health System Building Blocks

Service delivery	PROFILE OF HEALTH SERVICES The country's health care system consists of the formal and informal sector. The informal sector consists of traditional health practitioners and other unregulated service providers. The health service that is based on western medicine is considered to be formal and consists of public and private health services. The formal health sector is based on the concepts of primary health care and decentralization. Its infrastructure is made up of 7 government hospitals, 2 mission hospitals and 1 industry supported hospital. There are also 8 public health units, 12 health centers, 76 clinics and 187 outreach sites. In addition, there are 73 mission health facilities (health centers, clinics and outreach sites), 62 private clinics and 22 industry-supported health centers and clinics (National Health Policy: Swaziland). There has been a lot of investments made in improving coverage of health facilities and ensuring that health facilities are within a radius of 5 kilometres of the population. Currently, 80 percent of the population is within a radius of 8 kilometres. Over the last 10 years, the number of health facilities have doubled in Eswatini from 154 in 2006 to 327 in 2017 (SARA, 2018). The formal service delivery system in the country is structured around a four-tier system of service provision: tier one (community), two (clinics), three (health centres and regional referrals), and four (national referrals) as explained below. The service delivery system of the Eswatini Health Sector is organized in a four-tier system: i) Three National Referral Hospitals; ii) Regional Hospitals; iii) Primary Health Care facilities including Health Centers, Public Health Units (PHUs), Rural Clinics and a network of outreach sites; iv) Community Based Care where Rural Health Motivators (RHM), Faith-based Health care Providers, Volunteers and Traditional Practitioners provide care, support and treatment. Clinics are further divided into Type A and Type B, with the main distinction lying in the provision of maternity services: The Type B facilities offer maternity services while the Type A do not. The Public Health Units on the other hand concentrate on the provision of primary health care services, and constitute the base for outreach services, while the Health Centres have traditionally provided more of the curative and in-patient care as well as primary health care services. Furthermore, the revised EHCP 2016 divided the healthcare system into five (5) health service delivery levels where Level 1 relates to the delivery of health services at the Community level; Level 2 relates to the delivery of services in Primary Health Care facilities comprising of Clinic Type

	A, Clinic Type B and the Public Health Units; Level 3 relates to delivery of services in the Health Centres while Level 4 relates to delivery of services in Regional Referral Hospitals and lastly; Level 5 relates to delivery of services at the National Referral Hospitals. • **Community**: This level is the foundation of delivery service. Services at this level include community-based promotion, prevention and basic curative care. • **Clinics**: Clinics are categorized into Type A (without maternity wing) and Type B (with maternity wing). Clinics form the backbone of the primary health care infrastructure. They are the bases from which primary care programmes operate and provide first-line curative and emergency interventions to the rural population (How many clinics are in Eswatini classified as Type A and Type B? And how many are there in total (Type A + Type B). • **Public health units:** The public health services include promotive, preventive, outpatient curative health services, outreach care and interface with community-based health systems, including households and individuals. How many Public Health Units are in Eswatini? • **Health centres:** health centres provide an intermediate range of services at this level including promotive, preventive, outpatient curative, maternity, and inpatient services as well as diagnostic services, outreach care and interface with community-based health systems. How many health Centres a5a • **Regional hospitals**: Regional Referral hospitals provide, in addition to primary hospital services, curative and rehabilitative as well as selected specialist services. They are referral facilities and are responsible for providing technical support and supervision to sub-regional and primary health care facilities within their defined catchment areas. The regional hospitals may also provide in-service training, consultation and research in support of the primary health care programmes. • **National referral hospital:** There are three national referral hospitals, two of which are specialty hospitals, the TB and the psychiatric center, and Mbabane Government Hospital as the main referral hospital. Table 1.1 below described the distribution of health facilities across the regions and by type (Kingdom of Swaziland Ministry of Health 2012).

Table 2.1: Distribution of Health Facilities across Regions by type

Facility Type	Hhohho		Lubombo		Manzini		Shiselweni		Total	
	#	%	#	%	#	%	#	%	#	%
National Referral Hospital	1	1%	0	0%	0	0%	0	0%	1	0%
Regional Referral Hospital	1	1%	1	2%	2	2%	1	2%	5	2%
Health Centre	2	3%	1	2%	0	0%	2	4%	5	2%
Public Health Unit (PHU)	2	3%	2	4%	2	2%	2	4%	8	3%
Clinic with maternity	4	5%	12	24%	9	9%	6	13%	31	11%
Clinic without maternity	62	79%	33	65%	79	76%	33	69%	207	74%
Specialized Clinics	6	8%	1	2%	10	10%	4	8%	21	7%
Specialized Hospital	0	0%	1	2%	2	2%	0	0%	3	1%
Total	**78**	**28%**	**51**	**18%**	**104**	**37%**	**48**	**17%**	**281**	**100%**

There has been a lot of investments made in improving coverage of health facilities and ensuring that health facilities are within a radius of 5 kilometres of the population. Currently, 80 percent of the population is within a radius of 8 kilometres. Over the last 10 years, the number of health facilities have doubled in Eswatini from 154 in 2006 to 327 in 2017 (SARA, 2018).

About 85% of the country's population lives within a radius of 8km from a health facility (MOH policy 2007). Functionally, the public health system is decentralized from the central MoH to the four Regional Health Offices (RHO) in all regions of the country namely, Hhohho, Manzini, Lubombo and Shiselweni. The MoH performs executive and administrative functions, as well as providing strategic guidance on the delivery of the Essential Health Care Package (EHCP) at all levels of service delivery. At the regional level, it is the responsibility of the regional health offices to implement national health policies and plans. The RHO is supported by the Regional Health Management Team (RHMT) whose mandate is to provide technical leadership in executing MoH policies.

At the community level, there is a network of community health workers, i.e., rural health motivators (RHMs) and their role is to promote community participation in health activities. There are also community health committees that assist in the general management of health facilities.

Health services provided by Non-Governmental Organizations (NGOs), including Faith Based Organizations (FBOs) and the private sector, are regulated, closely monitored and partly funded by the MoH.

The health service system consists of three main levels: primary, secondary and tertiary. At the primary level, there are community-based health-care workers, such as 4700−5000 RHMs and various HIV and AIDS programme volunteers, 162 clinics (24 clinics with maternity services and 138 clinics without them) and 187 outreach sites run by nurses. The secondary level comprises of five health centres which offer

	both outpatient and inpatient services (with 20−40 beds) and eight public health units for referrals. The health centres also serve as referral points for the primary level. The tertiary level comprises of four regional hospitals – one in each of the four regions. The country also has two specialized hospitals (a national psychiatric referral hospital and a national referral TB hospital). The quality and availability of health services is affected by the distribution of resources. According to the WHO situational analysis of the health workforce in Swaziland, the ratio of doctors and nurses to the population was 1: 5 953 and 1: 356, respectively.
Health workforce	The country still faces acute challenges with the health workforce. Production of the required health workforce is inadequate. The absence of norms and projections are inappropriate, and the in-country capacity to produce several required staff cadres (particularly specialized cadres) is poor. The medical specialists are currently accounting for only 17% of the total doctors. Distribution of the available health workforce is also poor, with most specialised health workers concentrated in a few, centralized facilities leaving gaps in the availability of cadres at most peripheral facilities. To mitigate the current shortage, several donors are supporting several positions however the planning for the recruitment and absorption of these positions is poorly coordinated leading to real risks of failure to retain them. There are still weak management systems for the health workforce. Staff job descriptions are not aligned to their current tasks, and services are outdated particularly in the public sector. Performance monitoring is weak. Mechanisms to motivate the workforce are limited in roll out and scope. There are challenges with coordination and quality of in-service and pre- service training. There is duplication of in-service training by partners, and the training is not always facilitative of professional development in line with defined career paths of health workers and the priorities of the sector. Similarly, there are challenges in coordination of pre-service training particularly coordination between the MoH, MoET and MoL. Additionally, the capacity and facilities in training hospitals have been found to be inadequate for pre-service training hence affecting the quality of practicum training. Because of these challenges, the country has an inadequate workforce, which is inappropriately motivated and suffers productivity and retention challenges. Eswatini's community-based health services require strengthening. Eswatini initiated community-based health services through rural health motivators (RHMs) in 1976 to address key health challenges that were most prevalent at that time. Eswatini has more

	than 5,200 RHMs and other CHVs—including those that work in urban areas and who are collectively known as CHVs- that form an integral liaison between health care facilities and the community. They are accepted and respected within their communities. However, lack of standardization in the training of CHVs and their responsibilities has resulted in fragmentation with different messages and services being provided to communities, often causing confusion among communities. Due to this, as well the growing need for CHVs to provide more comprehensive PHC services, the MOH developed a standardized comprehensive training package for CHVs in 2018, to equip CHVs with the required knowledge, skills, and attitudes to provide community members the information and skills they need to access health care and ensure good health for themselves, their families, and their communities (World Bank Report. 2020). During MDA rounds for NTDs, these first line health workers collaborate with the certified nurses in delivering MDAs medicines. They play a major role in mobilizing the communities for the MDA.
Health information	The health sector recognizes the role of timely, complete, and accurate health information which helps in availing the required evidence for prompt decision making. Therefore, a fully functional and resourced health information system that provides strategic information for the health sector is critical if the health sector is to achieve its goals. Health information comes from various sources: The routine health management information system, which provides clients with generated data on health events, plus health management data relating to HR, infrastructure, commodities, and technology. Health research systems, which generate targeted information on selected topical issues. Surveillance systems, which collate disease specific trends and information. Vital statistics systems provide critical information relating to births, deaths, and cause of deaths in the country. Swaziland policymakers and health administrators decided to change from the paper-based health records system to an electronic health records (EHR) system. This change is being undertaken to harmonize healthcare data and improve patient care. The country's client management information system (CMIS) is an EHR system that improves patient care by improving data quality and access, reducing duplicated cases within the system, and improving patient flow and waiting times within the clinic. Swaziland is already using a CMIS for outpatient department (OPD) service modules for the main health programs: family planning, antiretroviral treatment (ART) for HIV-positive patients, antenatal care and prevention of mother-to-child-transmission

(ANC/PMTCT), tuberculosis, child welfare, and outpatient curative services. It is also using registration, laboratory, and pharmacy modules. The CMIS is being implemented in Swaziland by the Ministry of Health's Health Management Information Systems (HMIS), with support from the Institute for Health Measurement (IHM). It is being financed by the Swaziland Ministry of Health (MOH), with help from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and United States Agency for International Development (USAID). The CMIS pilot began in 2014 with one site and two more were added in 2015. The MOH's goal was to have the CMIS live in 134 facilities by 30 September 2017 in the four regions of the country. To date, 82 facilities have implemented CMIS. Of those, 69 have gone live since the beginning of 2017. The number of CMIS sites implemented in 2017 represents a rapid scale-up following delays in the implementation of the project, such as procurement of equipment and a lack of wide area network connectivity in some facilities. The project implementation was undergoing a "pause and reflect period" at the time of the interviews to address issues being experienced by the users before continuing to implement the system in other facilities in the following quarter (Eva Silvestre. 2017, Measure Evaluation. 2019).

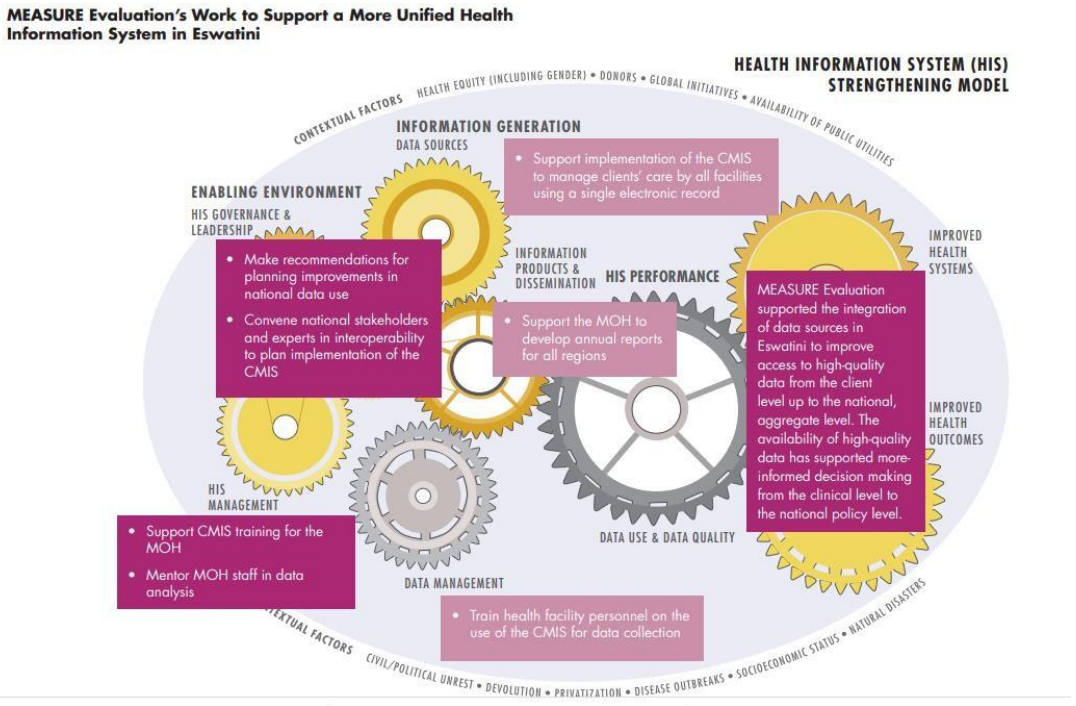
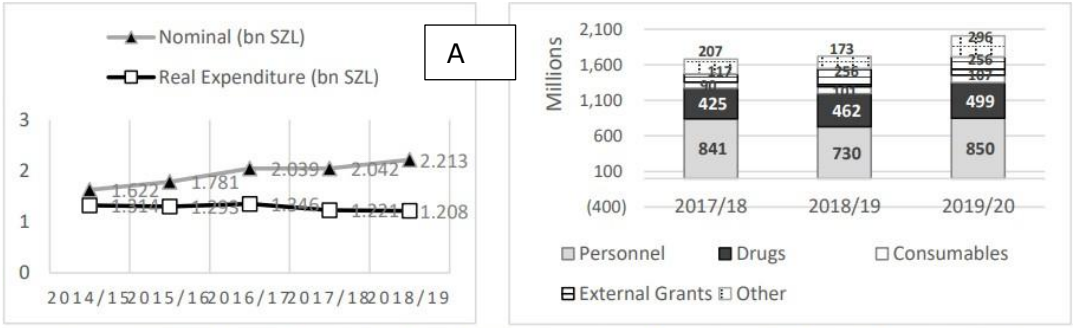


Figure 4.1: MEASURE Evaluation's Work to Support a More Unified Health Information System in Eswatini
(**Source:** Measure Evaluation. 2017).

Disease surveillance has significantly improved, with better availability of surveillance and laboratory data. However, the system is not yet vigilant enough to monitor some

	communicable and non-communicable diseases and other emerging and re-emerging diseases/conditions. If the NTDs programme is streamlined in the National Health system whereby the NTDs can be routinely detected at health facility level and being reported like any other health problems, the data communicated to the National Office through this efficient electronic reporting system would facilitate quick analysis and reporting aggregated data on NTD by the country.
Medical products	Health products, vaccine and technologies are key inputs in the provision of quality health services. The health sector seeks to assure that the right product is available in the right quantity, in the right place, to the right client, at a price that individuals and communities can afford. This thematic area includes selection, procurement, warehousing and distribution, and rational use of health products, vaccines, and technologies. The procurement of health products is guided by the Government of Eswatini's Public Procurement Regulations of 2012. These regulations provide guidance on how public sector procurements will be carried out. In an effort to ensure that the products supplied to the kingdom of Eswatini are safe efficacious and of acceptable quality the MoH had the medicines and related substances act 9 enacted in 2016. This was to enable the establishment of the medicine's regulatory authority. In preparation for this, the ministry established the medicines regulatory unit which performs some of the functions of the authority. These functions include medicinal product listing, pharmaceutical establishment registration and inspection, aspects of quality control and assurance, clinical trial oversight and Pharmacovigilance. Companies desiring to bring products into the Eswatini markets have to register with the unit as a pharmaceutical establishment and then as an importer of medicines. During the registration as an importer, the company has to provide all the products that they wish to import together with accompanying documents that detail some of the quality aspects of the products. Documents such as the current and valid certificate of pharmaceutical products, the manufacturing license of the plant that produced the medicine and others. Once these documents have been reviewed and found to be acceptable the company is issue with an import certificate which is renewable Annually. Prior to importing a product, the importer has to furnish the unit with a proforma invoice for verification if the products being imported are actually on the product list. If all is well, they are given an import authorization for the products which is a requirement at customs. For products procured by the ministry, there are visual inspections on receipt to observe any physical defects, on the packaging, labelling and

	product itself. The quality control testing and post market surveillance are still being established with the hope of having a system of testing in place by the end of 2024. Initially this will be conducted for TB, HIV and malaria commodities with NTDs, and other medicines being incorporated as time goes. This is because the establishment of these systems is funded through global funds whose focus is on malaria, TB and HIV in the country. The Central Medical Store (CMS) is the national warehouse for health products, vaccines and technologies. This facility is currently undergoing restructuring towards greater efficiencies and optimization of the limited space available. Distribution of health products is currently done from the national warehouse directly to facilities according to a predetermined schedule. The MOH established the Procurement Unit to lead the procurement functions for all health goods and services. The unit works with the government Tender Board in the Ministry of Finance. **Constraints to the supply logistics for the control of NTDs** Since the supply of the NTD medicines are do through existing National logistics, there have not been any challenges with distribution of medical products for NTD control in Eswatini. What has not been effective is the collaboration between the NTD program with the medicines control authority to the extent that there is no existing comprehensive pharmacovigilance system and existing opportunities for information exchange and incorporating the activities and processes of the pharmacovigilance system into NTD programming.
Health financing	National health policies typically focus on improving the population's health and preventing diseases and health hazards so that their entire population can aspire to a healthy and happy life and thus productively contribute to the prosperous development of the country and its economy. The achievement of national health objectives is eventually achieved through the selection of an adequate and efficient combination of methods of financing, organizational delivery structure for health services and payment approach for health providers. In addition, other structural elements contribute to the achievement of health objectives, such as the regulatory framework and programmes of public education. The approaches to mobilizing resources typically include a mixture of general taxation and contributions to public health systems and private health insurance schemes. The main methods of financing for health care include the national health insurance system, general revenue, private insurance, community-based insurance and out-of-pocket payments. The choice of methods will impact on who bears the financial burden, the amount of resources available and who manages the allocation of resources (Douin A. 2008). Health financing is a core function of health systems that can enable progress towards universal health coverage by improving effective service coverage and financial protection. Today, millions of people do not access services due to the cost. Many others receive poor quality of services even when they pay out-of-pocket. Carefully

	designed and implemented health financing policies can help to address these issues. For example, contracting and payment arrangements can incentivize care coordination and improved quality of care; sufficient and timely disbursement of funds to providers can help to ensure adequate staffing and medicines to treat patients. 10.1% of total expenditure is spent on health in Eswatini, which falls far below the government commitment to scale up health spending and meet the 2001 Abuja Declaration of 15% of all resources generated to be allocated to health. While Eswatini's spending on health increased between 2017 and 2019 (Figure 4.1A), macroeconomic challenges have led to reduced fiscal space for health. The FY20/21 health sector budget is SZL 2.2 billion (US$ 126 million), up from SZL 2.0 billion (US$ 140 million) from the previous fiscal year. This represents 10.5 percent of the total government budget. In real terms, however, the sector's budget has declined (Figure 4.1A). The breakdown by economic classification shows that personnel and drug expenses take up nearly two-thirds of the budget. Recurrent expenditures account for around 90 percent of the budget while capital expenditure and budget for maintenance are limited (Figure 2B). Administrative data suggest that spending on preventive and curative medicine is limited, respectively about 7 percent and 0.1 percent of recurrent expenditures. Furthermore, important areas such as nutrition and NCDs have been underfunded. Support from development partners (DPs) (approximately 24 percent of total health expenditures) is also expected to decline. While there is a Health Financing Policy, there is no clear health financing strategy and limited capacity to implement sustainable health financing mechanisms such as strategic purchasing that are critical for Eswatini to progress toward universal health coverage (UHC) and fulfill its human capital potential (World Bank Report 2020).  *Source:* UNICEF Health Budget Brief 2018/2019 – Kingdom of Eswatini; GOE Budget Estimates 2020. **Figure 4.2: Eswatini Budget expenditure 2014-2019**
Leadership and governance	The MOH performs executive and administrative functions, as well as providing strategic guidance on the delivery of the essential health-care package at all levels of service delivery. The Minister of Health oversees the Ministry, while the Principal Secretary for health is the accounting officer, technical lead, or head of Ministry. Reporting to the Principal Secretary for Health is the Director of Health Services with three Deputy Directors of Health services (Clinical pharmaceutical and Public Health),

	below these are programme and unit managers. At the regional level, it is the responsibility of the regional health offices to implement national health policies and plans. The RHO is supported by the Regional Health Management Team (RHMT) whose mandate is to provide technical leadership in executing MOH policies. The MoH also works with a number of partners including the United Nations Population Fund, the World Bank, WHO and local and international NGOs. In Eswatini, health services are delivered across primary, secondary and tertiary levels. Currently there are no reforms that are conducted in the country**.** The existing conditions of health reforms and Primary Health Care (PHC) are supportive of NTD control activities. With the exceptions of produced National NTD master plan there has not been any national policy on NTD control. NTDs are included in the health sector strategic plan, although there has not been specific funding allocation for NTDs control from the fiscus. The existence of health workers dedicated for NTD control, and the successful implementation of government coordinated MDA rounds in Eswatini over the past years, demonstrate their inclusion in the health sector strategic plan. There is no national coordinating body overseeing all control programmes. .Currently there is no National NTD programme. NTDs are under the Malaria control programme. There is no special unit dedicated for the NTD programme coordination. This shows an existing leadership gap for the control of NTDs. According to the guidelines on import procedures for medicines, the Ministry of Health in Swaziland has a responsibility of assuring the quality, safety and efficacy of medicinal products used nationally. Thus, it is responsible for pharmacovigilance and for investigation, analysis, and reporting of serious adverse events (SAEs). This function is implemented under the Pharmacy Department. Until now, there has not been a flow of communication between the Pharmacy department (pharmacovigilance unit) during the implementation of MDAs. The staff within this unit have not been aware of when and where mass drug administration was being planned and they have not been fully participating in investigation and reporting of SAEs. The NTD programme has not been that visible to the extent of mobilizing for multi-multisectoral' collaboration, however, it is notable that there has been recognition of the University of Eswatini during implementation of mapping of some key NTDs such as schistosomiasis and soil transmitted helminthiasis in the country. The major school-based activity on NTDs has been the annual rounds of school-based mass drug administration for schistosomiasis and soil transmitted helminthiasis targeting school age children. There is no information existing on the inclusion of NTD control in the primary school curriculum. The Department of veterinary services has been conducting vaccination of anti-rabies campaigns in the country. All cases of bites have been considered as suspected rabies

	cases warranting quick vaccination and treatment of affected cases. This exercise has maintained the level of rabies in the country at a very low level.

Section 1.3. Gap Assessment

Implementation of NTD control in Eswatini began with a focus on schistosomiasis and soil transmitted helminthiasis using Mass Drug Administration and case management as the main stay control strategies. Initially only a single NTD Focal person spearheaded control of Schistosomiasis and STH in Eswatini dating back from 1999.to 2019 The Neglected Tropical Disease Unit has always been run under the Environmental Health at the Ministry of Health which has been responsible for coordinating NTD activities in the country.

There have been no new diagnostic tools for a long time now to enable people in low resource areas to equally access point of care diagnosis for them to access medicines at primary health care level. Eswatini has no point -of care diagnostic tools for surveillance of all the NTDs to at community and health facility level, to provide sustained and reliable data for early detection and rapid response mechanisms.

There is limited collaboration in planning and implementation for NTDs at country level in Eswatini. Coordination, and inter-sectoral collaboration necessary for the elimination of NTDs in Eswatini has not been realized fully. Many of the NTDs endemic for in Eswatini have not been comprehensively mapped, thus, data is lacking to plan appropriate intervention strategies. Coordination mechanisms and stakeholder responsibilities as well as effective coordination and working processes to implement relevant interventions such as One Health approaches and integrated vector management are not yet embraced. The NTD programme has not yet received any financial contribution from the fiscus and only donor funding has sustained trickled in specifically for named NTDs, thus affecting sustainability of the NTD programme. Strategies for resource mobilization to address the funding challenge have not yet been developed.

Table 2.1: Gap Assessment

Domain	Specific area	dimensions
Technical	Scientific Understanding	There is lack of comprehensive epidemiological data on NTDs endemic in Eswatini: SCH, STH, TRA, Leprosy, Lymphatic filariasis, Snakebite Envenoming; scabies etc.
	Diagnostics	There is lack of effective, standardized, and affordable diagnostics for many of the NTDs specified in Eswatini. For Example, Diagnostic tools for NTDs especially STH, SCH scabies are not affordable or applicable in endemic areas where technical skills are still inadequate. Currently the Kato Katz and the urine filtration are used in diagnosis of SCH and STH, but these are not routinely used in public health facilities. This makes surveillance and consistent monitoring of these NTD difficult at all levels of health care and Public Health

Domain	Specific area	dimensions
		laboratory services. Health workers in trachoma endemic areas do lack skills for early diagnosis and confirmation as many of them are not trained. There is persistence in unavailability of the point of care diagnostic tests that are required in rural health facilities where many of the NTDs are endemic. Lack of POC diagnostics in low resource communities provides a barrier for surveillance, early detection of diseases and alleviation of the people affected with NTDs until late stages which are characterized with complications.
	Effective Interventions	There are no effective and affordable intervention for prevention, treatment, case management and rehabilitation of NTD cases. Other specialized support such as mental health and programmes to end stigmatization due to NTDs are still lacking (FGS, LF, trachoma, leprosy etc).
Strategy and service delivery	Operational and normative guidance	There is lack of technical guidance for validation or verification of elimination of NTDs. Access to interventions is still not equitable e.g., by hard-to-reach populations.
	Planning, governance, and programme implementation	There is no appropriate country governance and commitment for NTD programme management and effective delivery. There is lack of effective planning and implementation of NTD programme at national level. There is lack of safe administration of treatment, and diligent monitoring and response to adverse events during NTD-MDA interventions.
	Monitoring and evaluation	There is still lack of standardized mapping and impact assessment for detailed view of disease epidemiology and progression.

Domain	Specific area	dimensions
		There is no platform for continuous systematic institutionalized collection, analysis and interpretation of health data disaggregated by age, gender, location supported by strong data management system and tools to assist in data interpretation for informed decision making at all levels. Surveillance of NTDs is not yet institutionalized for sustenance.
	Access to logistics	Currently the supply of quality assured medicines, diagnostics, and other medical products for NTDs is not adequate at all levels. Supply chain is inefficient for effective allocation and distribution of medicines, diagnostics where they are needed, while minimizing wastage and loss.
Enablers	Advocacy and funding	There is no clear policy dialog and advocacy for NTDs. There is lack of domestic funding for the NTD programme
	Collaboration and multisectoral action	Currently NTD programme lack collaboration and multisectoral action, one health concept, WASH is disintegrated from NTD control programme
	Capacity and awareness building	The capacity to ensure high performing programme is needed through inhouse training or per-deployment training programmes, transfer of skills from vertical NTD programmes to primary health systems. Health worker attrition rate and in post gap has not been addressed.
		Health education about NTDs is not well capacitated or vibrant enough to educate the endemic communities e. g in behaviour change, MDA schedules treatment and care options.

Section 1.4. Programme Context Analysis

Eswatini is endemic or suspected to be endemic to 10 of the 20 NTDs. Categorized as follows: One targeted for elimination /interruption of transmission (Leprosy) ; 5 targeted for elimination as a public health importance (rabies, trachoma, LF, STH, SCH); and 4 that are targeted for control are eight (Scabies, Taeniasis, Food borne Trematodes and snake bite envenoming).

1.4.1. Current NTD Programme Organization and Status

Schistosomiasis and STH

The National Bilharzia Control Programme was established after a national schistosomiasis survey in 1982. The prevalence of bilharzia and intestinal worms has been decreasing over the years as shown by the data from health facilities reports (Figure: 4.3). This might be attributed to the introduction of the routine preventive chemotherapy of the Albendazole to the under-five years, pregnant women, and school aged children as from 2005 and Praziquantel to the school-aged children as from 2007. Some of the children however experienced some side-effects that required hospitalisation.

The National mapping survey of 2015 showed that all the four regions have two of the Preventive Chemotherapy (PCT) NTDs (Schistosomiasis and Soil Transmitted Helminths). According to the survey, there is a 15% prevalence of schistosomiasis and a 5.8% prevalence of Soil Transmitted Helminths (STH).

NTDs whose epidemiology has not been described through mapping.

The extent of endemnicity of Trachoma, Leprosy, Scabies, Taeniasis, Rabies, Snakebites, Foodborne Trematodiasis and Lymphatic filariasis is unknown although these NTDs are reported in individuals as isolated cases at health facility level. There is therefore a need to prioritise mapping of these NTDs using standardized methods to estimate precisely the distribution and severity of these diseases in the population. The section below explains the distribution of recently mapped NTDs.

Epidemiology and disease burden of schistosomiasis

Several surveys conducted in the country suggest that schistosomiasis and STH are co-endemic. A population-based survey was conducted between 1981 and 1984 during the Eswatini Rural Water Borne Disease Control Project which was supported by the USAID mission in Eswatini. The data were collected from 3,711 individuals. Urine samples were examined using the Petri dish method. The stool samples were examined at the Manzini Bilharzia Control Laboratory, where one gram of stool, as measured by liquid displacement, was transferred to a formalin-saline solution, and observed under a microscope. The prevalence studies showed that active transmission of schistosomiasis did not occur in the Highveld and *Schistosoma haematobium* (urinary Bilharzia) was found throughout the Middleveld with a prevalence of 34.5%. *Schistosoma haematobium* was also found in the Lowveld with an overall prevalence of 27.2%, but there was a difference between the northern Lowveld (58%), central Lowveld (23%), and southern Lowveld (17%). The sex distribution of *Schistosoma haematobium* showed a consistently higher prevalence in males than in females. The age distribution of *Schistosoma haematobium* showed that children aged 4-5years had a prevalence of 28%,. The peak prevalence was found in the 14-15-year-old group (41%). In the adults, the prevalence was 0. 5% in the over-30 age group. *Schistosoma mansoni* was rarely found in the Middleveld, with an overall rate of 2.3%. The age distribution of *Schistosoma mansoni* showed very early exposure with the 2-3-year-old children having 28% prevalence. The peak prevalence was found in the 18-19-year-old (47%). In adults, the infection rates remain relatively high at 18%. The distribution of *Schistosoma mansoni* was generally confined to the Lowveld. The northern Lowveld, central Lowveld and southern Lowveld had schistosomiasis prevalence of 30.9%, 12.9%, and 15.6 % respectively. The study also suggested a 2% prevalence of *Schistosoma matthei* around Mkhuzweni in the northern Hhohho region (Chinampa, 1982). No other study has reported *Schistosoma matthei* in the country.

A parasitological survey of *Schistosoma haematobium* was conducted in two remote areas in Hhohho and Manzini. The findings of the survey estimated the infection rate of *Schistosoma haematobium* at 5.3% with a geometric mean intensity of 46.5. Boys had higher prevalence (7.1%) and GMI (50.4) than girls 3.8%, GMI (40.0) ($p > 0.05$). Prevalence among Manzini schoolchildren was significantly higher t (14.6%) than among schoolchildren in the Hhohho region (2.9%), ($p < 0.001$). However, Hhohho schoolchildren had a higher GMI (70.2) than that observed in Manzini schoolchildren (21.9). Children from schools located in the Lowveld had a significantly higher prevalence (11.4%) than children from schools located in the Highveld (0.6%) ($p < 0.0001$) (Liao *et al*., 2011).

Another parasitological survey of *Schistosoma haematobium* infection among 295 residents of Siphofaneni in the lowveld, showed that *S.haematobium* overall prevalence was 6.1%. The mean age ± standard deviation: was 20.5 ± 18.1 years. Subjects with positive infection were

confirmed by the detection of *S. haematobium* ova in their urine using the centrifuge method (Chu *et al*., 2010).

The first nationwide schistosomiasis survey conuducted in in 1986, provided an estimated prevalence of schistosomiasis of 25%. The last nationwide survey of schistosomiasis was conducted and the prevalence results were reported by each Inkhundla (administrative areas) in 2015. High risk of schistosomiasis was reported in some Tinkhundla, 30.9%, 30.1%, 29.4%, 25%, 20.4%, etc. (Fig. 4.3). Basing on the 2015 survey results, in 2021 ESPEN estimated that 121 751 school age (SAC) and 119 065 adults were living in implementation units requiring Preventive Chemotherapy (PC).
Of the 55 tinkhundla, 2 had high (≥ 50%) prevalence, 38 had moderate prevalence (10-49.9%) whilst 14 implementation units had low prevalence of schistosomiasis (<10%).

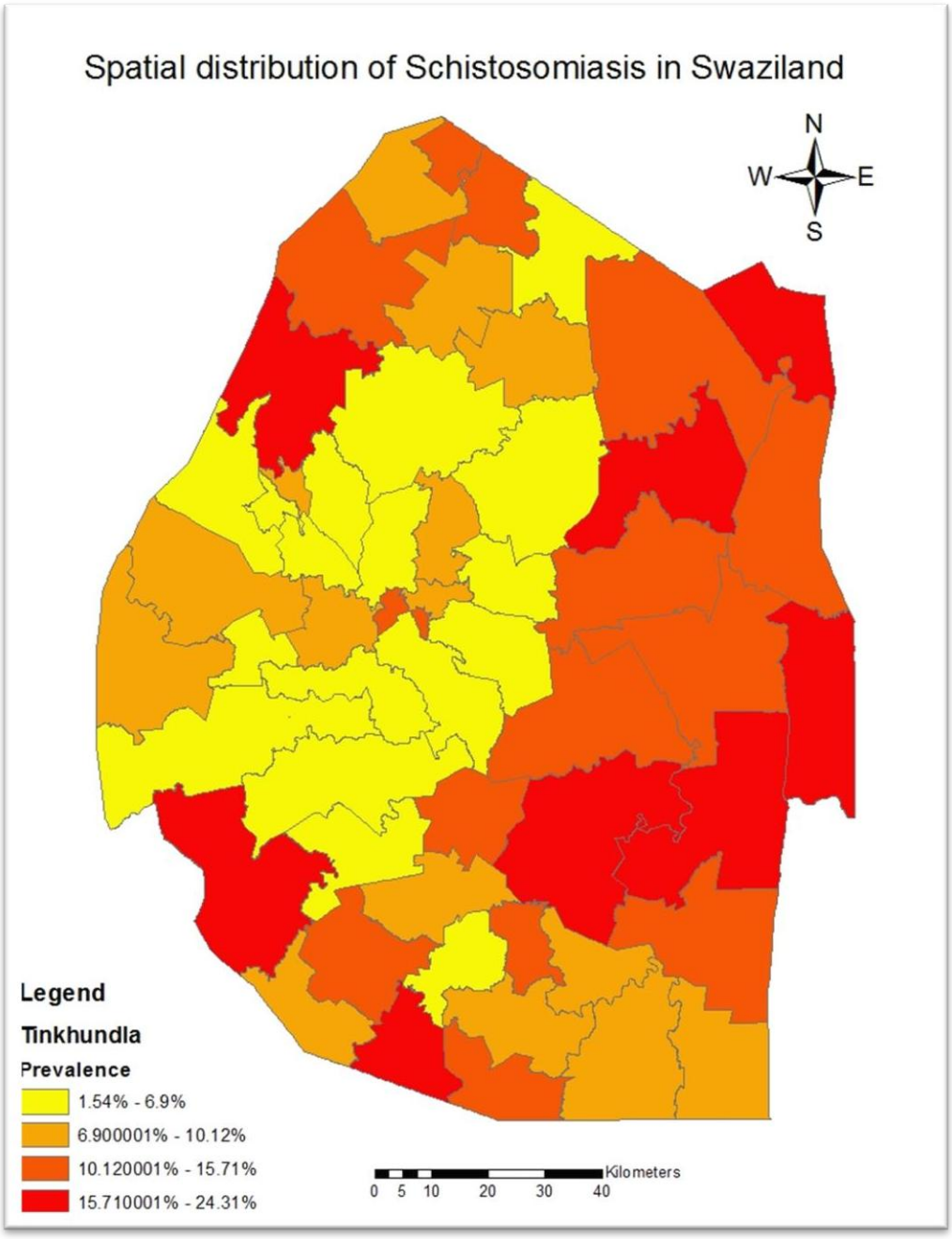


Figure 4.3: SCH Prevalence by Tinkhundla (constituency/ district) 2015

Following classification of Eswatine into endemicity status in 2015, biennial mass drug administration was implemented from 2016-2018. Figure 4.5 shows schistosomiasis preventive chemotherapy coverage trends over time in Eswatini (2016-2021). Due to COVID-19 pandemicity, the World Health Organization and member state endemic for NTDs including schistosomiasis suspended NTD programme activities from 2020-2022 to channel greater resources towards the control of COVID-19 pandemic. Thus, regardless of the schistosomiasis endemicity status of the tinkhundla in Eswatini, no MDA could be implemented during COVID-19 pandemic period (2020-2022).

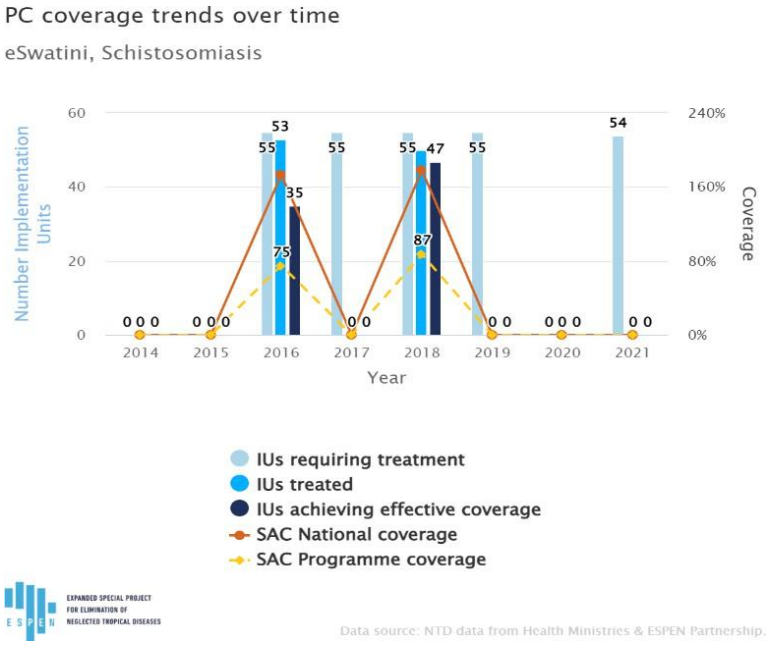


Figure 4.5: Eswatine schistosomiasis PC coverage trends (ESPEN 2021)

Figure 4.6 below shows the endemicity status across all endemic IUs from 2014 to 2021. In 2016 and 2017, no district registered a high prevalence of schistosomiasis. The high prevalence where noticeable in 2018 , 2019 and 2021. Observation of districts with high prevalence after 2018 suggests implications of suspending MDAs due to COVID-19 pandemic, on reinfections and the increasing burden of schistosomiasis.

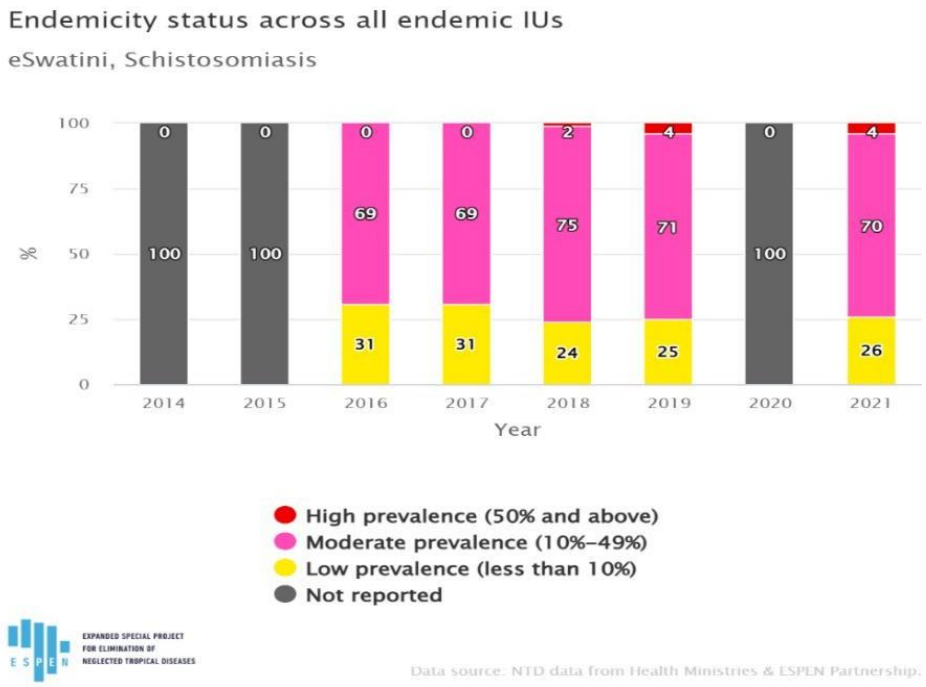


Figure 4.6: Eswatine endemicity status across all IUs (2021)

Figure 4.7 is a map showing the status of the national schistosomiasis elimination programme in Eswatini in 2021. It is apparent that the country has been achiving high MDA coverages at each of the MDA rounds implemented so far.

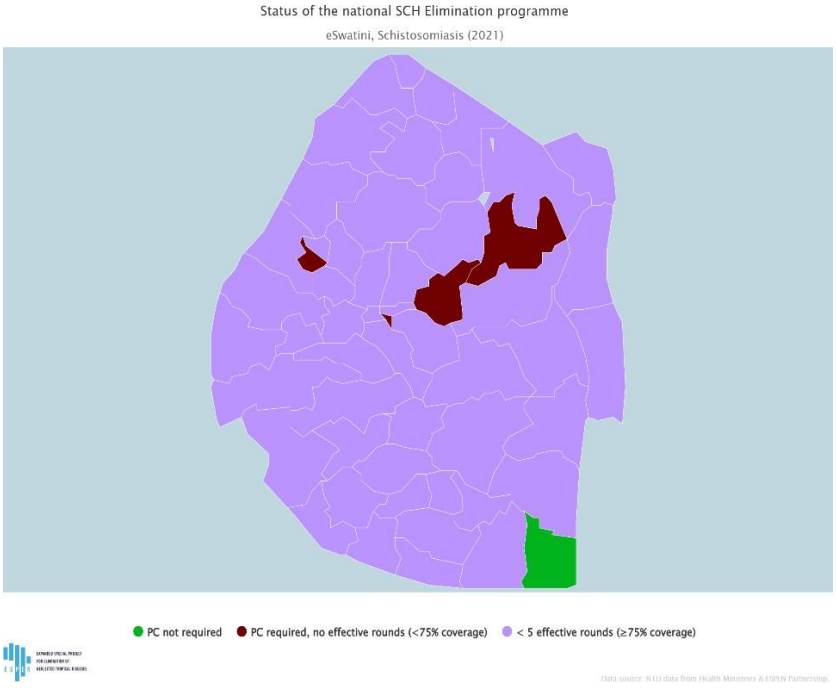


Figure 4.6: Status of Eswatini National Schistosomiasis Elimination programme (ESPEN 2021).

Gived the above results, it is apparent that if resouces are provided, Eswatini has the potential to eliminate schistosomiasis during the implementation period from 2024-2028. Figure 4.7 shows overlay of the WASH and schistosomiasis. Two districts, one with low water and sanitation coverage (in red) and another with low water but high sanitation coverage (in pink colour) had high prevalence of schistosomiasis. This emphasis the need for multi-sectoral collaboration and national coordination of partners interested in control of NTDs so that no place or population in NTD risk communities are left behind. Integrated approaches in control of NTDs enable intensification of NTD elimination process.

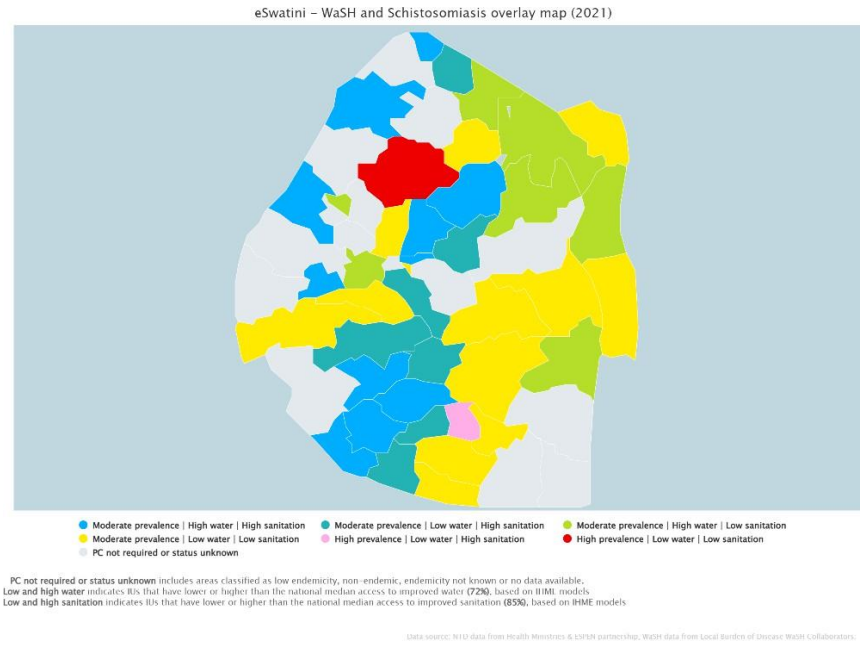


Figure 4.7: Eswatini WASH and schistosomiasis overlay map (ESPEN, 2021)

Soil-Transmitted Helminth

Epidemiology and disease burden

A survey to determine the burden of STH in 0-59 months was conducted in 2002 in the Lubombo and Shiselweni region. The findings suggested a prevalence rate of 27% in Lubombo and 42% in Shiselweni. The samples were selected from 10 health facilities in Lubombo and 11 health facilities in Shiselweni. In the laboratory the stool specimen was processed using the formal thither concentration technique.

A national soil-transmitted helminthiasis survey was conducted in 2015 to estimate the prevalence of soil-transmitted helminths (STHs) at the Tinkhundla level. High prevalence rates of STH of 24.6% and 23.0% were reported in two Tinkhundla, both located in the Highveld. Generally, the

prevalence levels in other districts as recorded were low but the distribution of STH is widespread geographically. Evidence of infection was not found in only three Tinkhundla (Fig. 4.8)

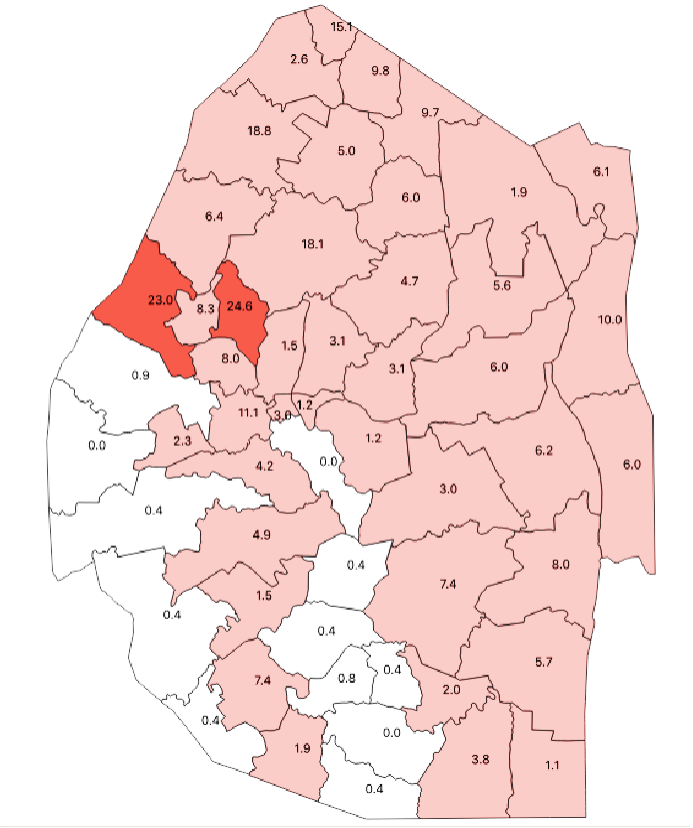


Figure 4.8: Eswatini STH endemicity and Prevalence by Tinkhundla (2015)

STH MDA coverage trends in Eswatini 2016-2019

Following the mapping of STH in 2016, a deliberate effort was taken by the government of Eswatini with support from WHO and interested partners to initiate mass drug administration complementing the water and sanitation activities. Figure 4.9 shows the STH coverage trends in Eswatini from 2016 to 2021. Notable is that even when the number of tinkhundla requiring MDA was few, the coverage of MDA included several tinkhundla (almost all tinkhundla) with high coverage. The non-implementation of MDA in 2020 and 2021 was in response to the World Health Organization's call for countries to suspend NTDs.

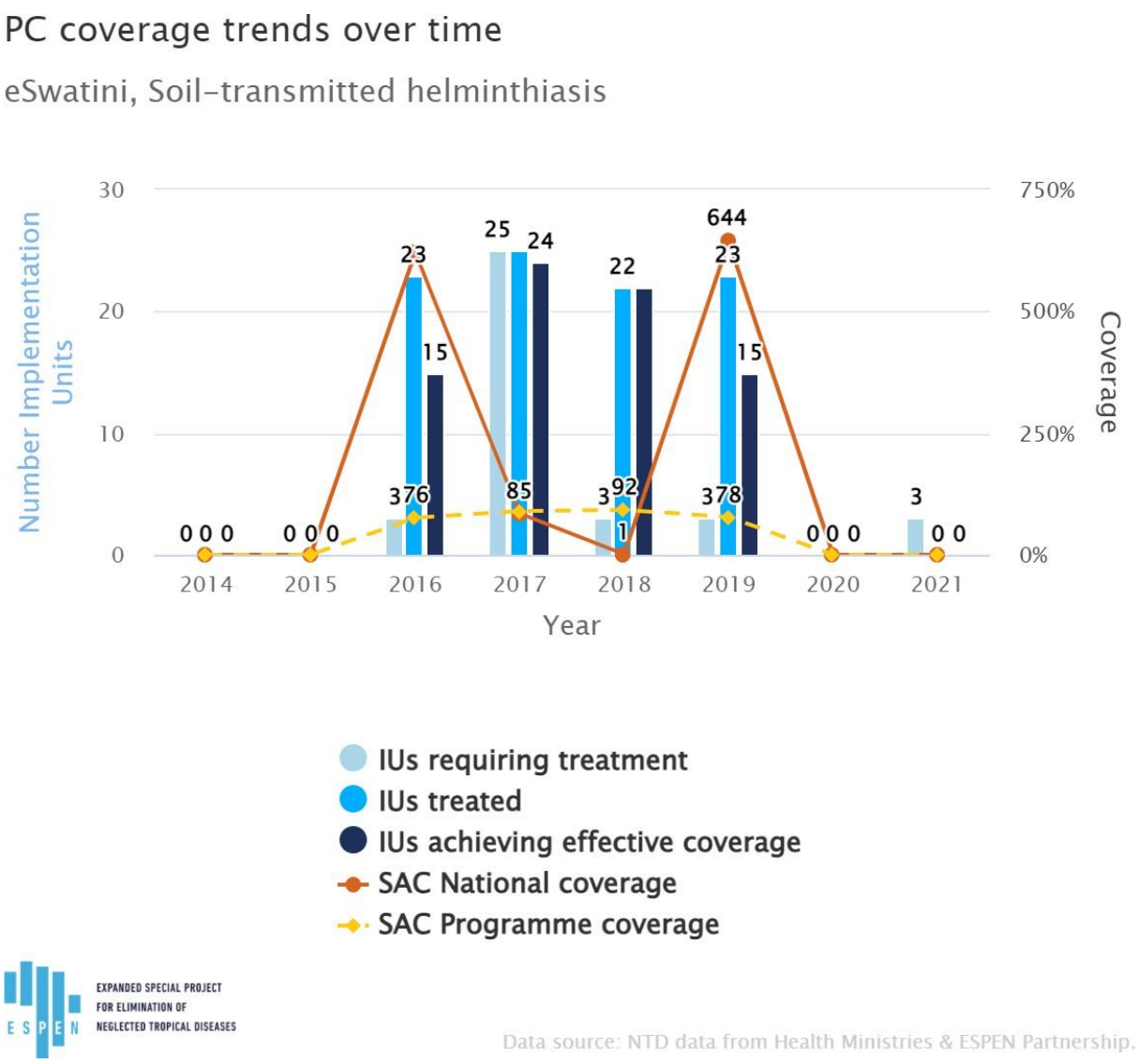


Figure 4.9: Eswatini STH Preventive Chemotherapy coverage over time**.**

Status of STH elimination programme in Eswatini

Figure 4.10 below shows the status of the STH elimination programme in Eswatini in 2021. This map is presented after several rounds of MDA in Eswatini (2016-2019). It shows that only 3 of the 55 tinkhundla required Preventive Chemotherapy. Thus, the high PC coverage implemented successfully from 2016 to 2019 surpassed the WHO-recommended effective coverage, and the national effort reduced the prevalence of STH to below the threshold for MDA (20%) in 52 of the 55 tinkhundla (95%).

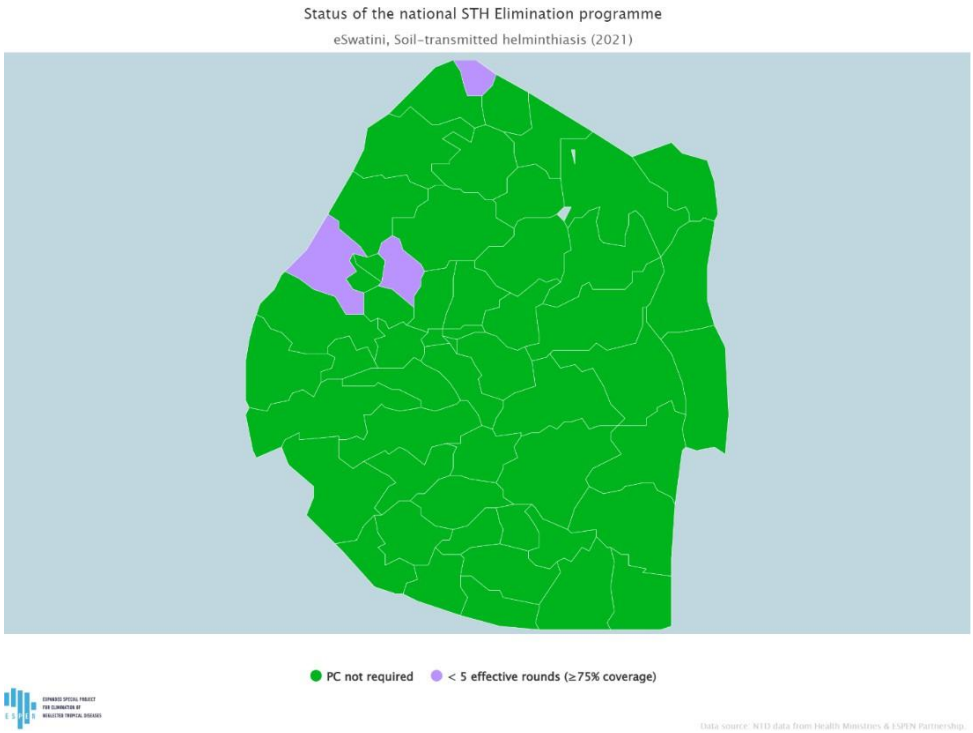


Figure 4.10: Status of the STH elimination programme in Eswatini in 2021

Lymphatic Filariasis

Lymphatic Filariasis is a debilitating disease that is estimated to affect 856 million people in 52 countries worldwide. It is caused by the filarial worm *Wuchereria bancrofti* and transmitted by mosquitoes of the genus *Culex* and *Anopheles*. Once infected the disease may not manifest for several years (up to 20 years) and causes debilitating tragic morbidity namely: -

- Lymphedema: swelling of the extremities; it can affect the breasts, legs and/or arms of both men and women. Once the damage has been caused, it is not possible to fix the damaged tissue.
- Hydrocele (scrotal swelling): inflammation is found around the genitals

The prevalence of lymphatic filariasis in Eswatini is unknown as no study has been conducted to determine the endemicity of the disease and there are no reports in the Health Management Information System (HMIS) suggesting active transmission of *Wuchereria banhcrofti*. HMIS data reports people with elephantiasis of one limb and men with hydrocele. No scientific evidence has been generated to confirm that these conditions are due to lymphatic filariasis.

Leprosy

Gaps and priorities for Leprosy:

Over the years data on leprosy was scanty in Eswatini. As a result, there has been limited effort in the control of the disease including health promotion, treatment, and surveillance activities. The main challenges are a lack of trained personnel, lack of funding and weak surveillance systems.

In August 2017, a new case of leprosy was diagnosed in Eswatini. It was investigated and managed in line with the recommendations of the World Health Organization. Following this new case, the old leprosy cases countrywide were revisited. It was observed that leprosy patients were found to be living in poor conditions and are often victims of stigma due to their condition.

The Ministry of Health's Annual Budget Performance Report for the year April-June 2022 indicated that there were leprosy cases countrywide. The ministry stated that it had noted with concern the re-emergence of infectious diseases like leprosy, which was last seen in Eswatini in the early 1990s. As a result, the ministry engaged the Deputy Prime Minister's Office to set up a system for the possible enrolment of these patients on the disability grant.

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Scabies

The cases of scabies in Eswatini have been increasing since 2022. Around 8536 cases of scabies were reported countrywide from January to September 2022. Comparison of the same period with 2021 shows an increase 27% (2332 Scabies cases in 2021). The most affected populations are school learners in the affected regions where access to water and sanitation facilities is inadequate. Figure 4.11 illustrates the trends of scabies from 2020 to 2022.

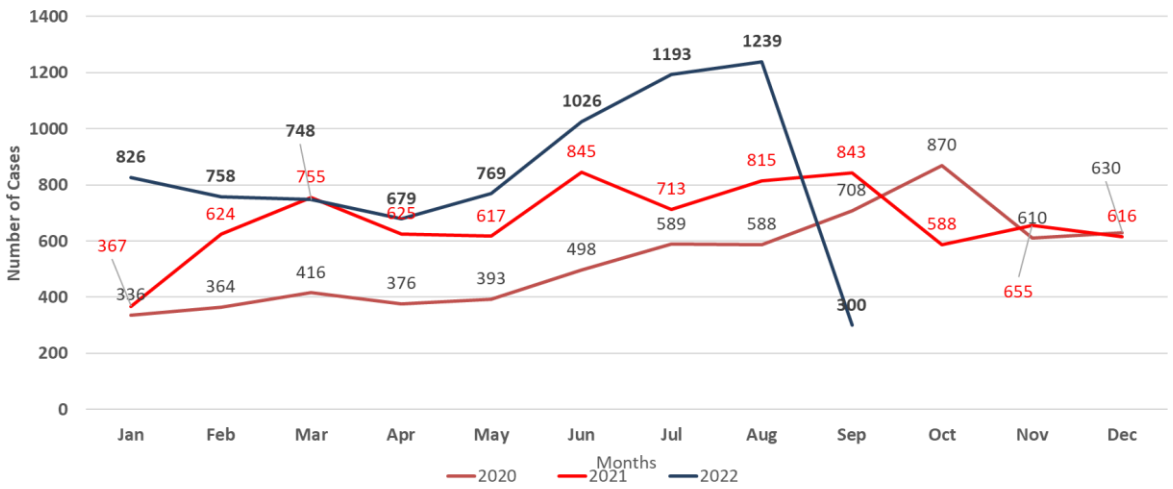

Figure 4.11: Scabies from 2020-2022 (HMIS)

Gaps and priority actions for Scabies:

Gaps and challenges for scabies include:

- Lack of accurate data on disease burden
- Lack of capacity for diagnosis and case management
- Lack of tool for intervention (threshold level for MDA)
- Lack of donated medicines for scabies

Priority actions for scabies:

- Advocacy and resource mobilization
- Develop implementation guideline for scabies control.
- Include scabies in the PHC package of care.
- Research and Development on scabies management
- Capacity building on scabies diagnosis and management

Snakebite Envenoming

Epidemiology and disease burden

Snakebite from venomous snakes is a medical emergency requiring immediate critical care by a medical team (Ahmed *et al.,* 2008). Failure to correctly manage a snakebite causes high morbidity and mortality (Warrell, 2010). Globally, the incidence and severity of snakebite envenomation has been severely underestimated, with most cases occurring in rural areas of developing countries (Chippaux *et al* 1998, Kasturiratne *et al* 2008).

In Eswatini, snakebite is a challenging public health issue, affecting all areas and populations of the country, with approximately 500 cases of snakebite envenoming presenting to hospitals and health centres each year (Padidar *et al*). Although perceived as a 'lowveld' issue, data collected by the Ministry of Health in collaboration with the Eswatini Antivenom Foundation demonstrate patients are bitten at all geographical elevations across the entire country. Snakes will bite anyone regardless of age, and national statistics show the age of snakebite victims range from newborns to pregnant women to the elderly, with over half of patients under the age of 30 years. Snakes typically become active in spring in Eswatini, and most patients are bitten during the summer months. Reports show that snake bites occur any time of the day, with a peak in bite incidence reported in the evenings.

Fatalities reported to health facilities and the Eswatini Antivenom Foundation range from 10-20 per year, with a drop of 75% in fatalities observed when dedicated snakebite assistants are stationed at health facilities during spring and summer. Most fatal bites reported were due to neurotoxic envenomation, with 20% due to cytotoxic envenomation to the head and neck, further highlighting the immediate emergency treatment necessary. Whilst Eswatini is geographically relatively well covered with rural clinics, only hospitals and health centres have the equipment and are staffed by medical doctors who can safely treat a venomous snakebite with antivenom. Consequently, large areas of the country are at the highest risk of snakebite with poor outcomes. In 2021, Eswatini revised and launched its national snakebite treatment guidelines. These guidelines also direct health care workers working at lower clinic level facilities as to how best to stabilize a patient and transfer them to higher level health facilities.

Whilst the incidence of snakebite and mortality from Eswatini appear low, data from other southern African countries have highlighted the severe underreporting of snakebite and snakebite mortality (Farooq *et al* 2022), primarily due to patients not presenting to health facilities. Therefore, Eswatini's statistics should also be considered largely underestimated. Community- based surveys, public education, and a reliable supply of effective antivenom at health facilities to improve public confidence will be needed to better elucidate the true snakebite burden in Eswatini. In 2022, Eswatini became the first country in the world to make snakebite a notifiable disease, marking the commitment of the Ministry of Health to meet the global goals of halving snakebite morbidity and mortality by 50% by 2030.

Table 3: National population data, schools, and health facilities at district level

Region	Number of Admin A 2	Number IUs	No. of villages or communities*	Total population	Under-5 (Pre-school)	5–14 years (School age)	Adults	No. of peripheral health facilities			
								National Referral	Regional Referral	Health Centres	Clinics
Hhohho	N/A	15	*	356412	24949	86605	231666	1	2	2	79
Lubombo	N/A	11	*	238910	16723	58054	155292	1	1	1	46
Manzini	N/A	18	*	409388	28655	99478	266105	2	2	0	98
Shiselweni	N/A	15	*	232854	16299	56583	151355	0	1	2	41
Total	**N/A**	**59**	*****	**1237564**	**86626**	**300720**	**804418**	**4**	**6**	**5**	**264**

***** = Data not available

N/A=Not applicable

Table 4: Known disease distribution in Iswatini

gion	**.** khundla	**mber of endemic** Tinkhundla									
			bies	H	H	p	E	T	en	A	abies
ohho											
bombo											
nzini											
iselweni											
tal											

Key:

* = unmapped

NTD Co-endemicity in Eswatini

The co-endemicity of NTDs in Eswatini is shown in Figure 4.11. Whilst 10 NTDs are endemic/suspected in Eswatini, the co-endemicity map was created using data from the NTD that have been scientifically and comprehensively mapped (schistosomiasis and soil-transmitted helminthiasis). The map also serves to show the NTD mapping gap in Eswatini. For the schistosomiasis and STH that have been mapped, they are co-endemic in the majority of tinkhundla. The population living in co-endemic districts is therefore exposed to exacerbated morbidity. The co-endemicity map shows how and geographically where are NTDs overlapping. This information is vital for planning cost-effective integrated control strategies for the NTD overlapping in space and in population (co-endemic).

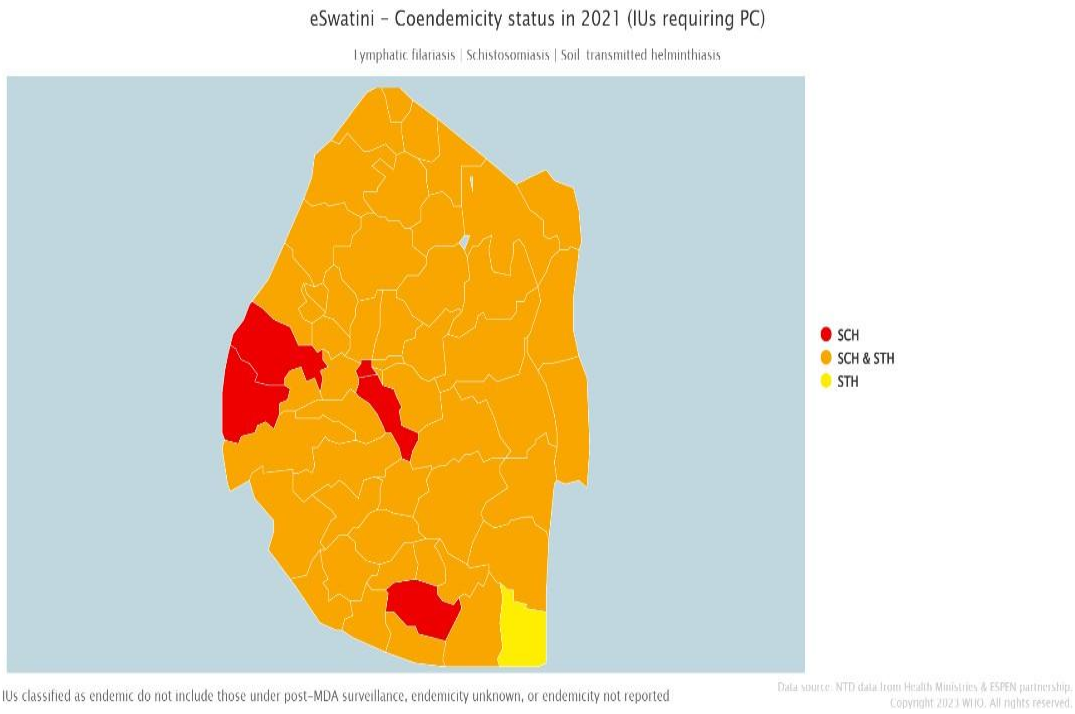

Figure 5: NTD Co-endemicity status in Eswatini (2021)

Source: ESPEN 2021

1.4.2. NTD Programme Performance

In this section, information on key results, impact, and trend analysis of the NTD programme are provided. List the past and ongoing NTD control programmes. The information should be organized into the following sections:

a) Completeness of the mapping and survey needs.

Mapping of the various NTDs to understand the burden of these diseases was not conducted, it is only SCH and STH that was done in 2015. The baseline data for SCH and STH was used for the implementation of the NTD prevention, control, elimination, and eradication activities (see table … below on mapping status of NTDs).

The NTDs completely mapped include schistosomiasis, and STH. Although the health facility reports show that snakebite envenoming and scabies have been documented in all tinkhundla, there is still the death of epidemiological data obtained through systematic mapping of these two NTDs. The remaining NTDs: TRA, LEP, TAE. FBT, LF and RAB are suspected and hence require confirmatory mapping to systematically determine their endemicity. Table 5 describes in detail the completeness of the mapping and survey needs.

Table 5: NTD mapping status 2024

Endemic NTD	Total # Tinkhundla	No. of endemic Tinkhundla	No. of Tinkhundla mapped or known endemicity status	No. of Tinkhundla remaining to be mapped or assessed for endemicity status
Schistosomiasis	59	59	59	0
Soil-Transmitted Helminthiasis	59	59	59	0
Trachoma	59	-	-	59
Rabies	59	-	-	59
Snakebites	59	59	59	59
Leprosy	59	-	-	59
Lymphatic filariasis	59	-	-	59
Foodborne Trematodiasis	59	-	-	59
Scabies	59	59	59	0
Taeniasis	59	-	-	59

Key: - = Not yet mapped.

1.4.3 Performance of the other programmes that are closely related to the NTD programme.

Vector control: Integrated Vector Management (IVM)

LF, SCH and malaria are targeted for vector control in Eswatini based on their life cycles. The integrated vector management (IVM) approach is implemented in the country with a focus on malaria. In the country, the four ecological zones contribute to the receptivity of malaria and bilharzia. Transmission is most prevalent towards the east of the Lubombo region, where approximately a third of the country's population lives and is at risk of the two diseases. The malaria and Vector-borne Diseases Control Strategy (IVM) demonstrates the Ministry of Health's determination to integrate the control of all vector-borne diseases through the implementation of IVM. Although there was no deliberate intervention action on LF mosquito vectors. Naturally, the interventions for malaria vector mosquitoes were also covering for its control. The country has not been implementing intermediate host snail control for SCH the current NTD master plan envisages embracing control of intermediate host snails in hotspots for SCH. In areas where both SCH and malaria are transmitted, treatment of breeding sites for both malaria mosquito vectors and SCH intermediate host snails becomes amenable to integration (Table 6). Currently, the IVM has not been embraced in Eswatini, only malaria vector control interventions have been ongoing. The key ongoing vector control interventions include ITN and IRS for malaria only.

IVM for Vector-borne diseases including NTDs in Eswatini

Table 6: Vectors and Associated NTDs

Activity	Mosquitoes		Other Vectors
			Snails
	LF	Malaria	Schisto
ITN	X	X	
IRS	X	X	
Space spraying			
Larviciding	X	X	
Traps			
Prevention/treatment of breeding sites	X	X	x

One-Health

One -Health is a collaborative multi-sectoral, and transdisciplinary approach working at a local or national level to achieve optimal health outcomes recognising the interconnection between people, animals, plants, and their shared environment. Alternatively, it is defined as an integrated approach to building an understanding of human-animal transmission of NTDs with an animal interface and delivering interventions such as vaccinations, population management and tethering for dogs. One Health is a collaborative, multi-sectoral, and trans-disciplinary approach to addressing the health threats of humans, animals, and the environment. Diseases including Rabies, SBE etc. will benefit from the One Health approach. Collaboration with the Ministry of Agriculture on Rabies and Eswatini Antivenom Foundation on SBE for data/information exchange, and collaboration on control interventions. Naturally, the programme to vaccinate dogs has been a deliberate action to prevent both dogs and human from rabies. The same concept has not been applied to other NTDs such as Taeniasis.

WASH

A proportion of the population uses improved drinking water sources in urban and rural areas. Access to safe water and sanitation is a very important ingredient in the control and prevention of human health and as such intervention should be incorporated in the prevention strategies. About 91% of the urban population has access to safe water, while only 37% of the rural population has access according to Swaziland Human Development Report, in 2000. More recent reports show that rural access to safe water improved to 58% in 2007 (DHS, 2007) and to 60% in 2010 (MICS, 2010). According to MICS 2014 access to safe water improved in urban areas to 96% while in rural areas it improved to 63%. Access to safe sanitation shows a decline from 73% in 2010 to 55% in 2014. Notably though, was that there was an increase in urban water access from 91% in 2007 to 96% in 2014. Rural access to safe water increased from 58% in 2007 to 63% in 2014 as shown in Figure 5.44. The recent Eswatini Household Income and Expenditure Survey (2017) has indicated that 76% of the households use improved sources for drinking water.

There has been a drastic decline in sanitation coverage both in urban and rural areas in 2014. The reason is that there has been a revision of the definition of improved sanitation. So, this implies that some of the structures previously regarded as improved sanitation no longer meet the minimum standard and as such are now considered unimproved. According to the National Sanitation and Hygiene Policy, 2019, only 58% of the country's population have access to basic sanitation facilities, and about 11% practice open defecation. It is worth noting that the country was not able to meet its Millennium Development Goals (MDGs) target on sanitation in 2015. It is also unlikely that Eswatini will meet its sanitation coverage target of 100% by 2022 as set out in the National Development Strategy (NDS).

School Health

A lot of NTD prevention and control interventions are conducted in the school. School Health and Nutrition Strategy helps to have sustainable and quality health and nutrition interventions across the education sector and strengthens coordination, linkage and partnership with relevant ministries, communities and other stakeholders. MDA is also conducted for school-age children at the school level with the involvement of the school community.

NTDs and Gender and Equity

Based on the exposure status some of the NTDs are more prevalent in specific gender group. Some of the NTDs are more prevalent in women and to worsen the matter the health-seeking behaviour (affected by the level of education, access to resources, household decision-making power and physical access to health facilities) is often found to be low for women.

Embracing the idea of gender equity and human rights (GEHR) and promoting equality concerning gender (Goals 5 and 10 of the SDGs), should be the area of focus in implementing the NTD interventions. Hence it is necessary to ensure that all services for NTDs should be based on gender equity and human rights. Data disaggregated by gender will help to better understand this and better involvement of women, and empowerment in decision-making could improve the utilization of NTD services.

Sustainability of NTD programme

Sustainability of the NTD programme is very essential to achieve the national and global target for NTDs and contribute to the attainment of the SDGs. And for this, the key focus areas are: Improve multi-sectoral coordination (Health, Education, WASH, Agriculture, Finance, MCH, etc), improved implementation capacity through improved HR capacity, NTD programme ownership at all levels; including domestic funding for NTDs and strengthening national HIMS for informed decision making.

Pharmacovigilance

Because the NTD program uses millions of doses of medicines for MDA, proper monitoring and recording of adverse events, providing reliable, balanced information for effective assessment of the risk-benefit profile of medicines, and communicating findings to the relevant national regulatory department are critical for timely management, proper investigation, and communication. The national pharmacovilance center (NPC), which is part of the medicine's regulatory unit, oversees patient safety. In the kingdom, there are two types of surveillance system: passive and active.

In the country, the active system is used for novel and repurposed medicines, particularly those used to treat tuberculosis and HIV. All medicines that are not subject to active safety monitoring are subject to the passive system. Reporting is still done on paper, with only a few

facilities offering active reporting forms and all facilities offering passive reporting forms. Serious adverse events must be reported within 48 hours of becoming aware of them. Pharmacovigilance of medicines used in the Eswatini NTD program has been largely done by the NTD program outside of the NPC's involvement; consequently, the NPC has not received any reports related to NTD intervention. PV activities must be integrated into the NTD program to ensure the overall patient safety of people taking NTD medications. This can be accomplished through community awareness, drug provider and health worker training, and the distribution and use of the national ADR reporting format.

Summary of intervention information on existing NTD programmes

Table 7 below describes existing intervention strategies for NTDs. For noting is the fact that intervention strategies (MDA)for STH and SCH were implemented on four successful rounds/years, until 2019. Thus, the country is yet to implement the fifth round of MDA after which impact assessment can be recommended. Thus, in table 7 the number of districts targeted for MDA intervention for SCH and STH is 59. The same number of districts will require another effective round of MDA intervention (Table 7). However, notable is a gap in MDA rounds created from 2019 to 2022, largely by the advent of COVID-19 pandemic which resulted in suspension of implementation of other essential health care programs including MDAs for NTDs. It is against this background that the country proposes conducting a survey on the burden of SCH and STH before the fifth round of MDA in order to access the impact of COVID-19 pandemic on NTD interventions and disease burden (prevalence).

Table 3: Summary of intervention information on existing NTD programmes

NTD	Date programme started	Total Districts targeted	No. districts covered (geographical coverage*)	Total population in target district	No. (%) Covered	No. (%) districts with required number of effective treatment rounds	No. (%) districts that have stopped MDA	Key strategies used	Key partners
LF	α	59	α	A	α	α	α	α	**α**
Foodborne Trematodiasis	α	59	α	A	α	α	α	α	**α**
SCH	2016	59	59 (100)	1 200 000	α	59 (100)	59 (100)	MDA	WHO, UNICEF, CHAI
STH	2016	59	59 (100)	1 200 000	α	59 (100)	59 (100)	MDA	WHO, UNICEF, CHAI
TRA	α	59	α	A	α	α	α	α	**α**
SBE	2021	59	59 (100)	1 200 000	α	59 (100)	59 (100)	Case management	Eswatini Antivenom Foundation
Taeniasis	α	59	α	A	α	α	α	α	**α**
Scabies	α	59	59 (100)	1 200 000	α	α	α	α	**α**
Rabies	α	59	α	A	α	α	α	α	**α**
Leprosy	**α**	**59**	**1(1.7)**	**A**	**α**	**α**	**α**	**α**	**α**

Key:

α = Not estimated

Section 1.5: Building on NTD Programme Strengths

The results of strengths, weaknesses, opportunities and the threat of the programme is summarized in Figure 6

Table 7.1: SWOT analysis

Strengths	*Weaknesses*
1. Existence of a skeletal mass of HR with institutional memory of NTD program 2. Availability of drugs. 3. Availability of partners to support in implementation of NTD activities. 4. The availability of the program management (Chief E.H.O and Program manager) 5. The existence of malaria vector control and integration of the malaria program and bilharzia program 6. The global action to integrate NTDs. Commitment from national government 7. Partially established NTD programme though not well defined 8. The country has experience in tackling NTDs. 9. Have eliminated leprosy as a public health problem (reduction of the prevalence rate to less than one case per 10 000 populations) at national level	1. Lack of professional disciplines in the NTD Program. 2. Inadequately defined structure of NTDs management. 3. Lack of knowledge and skills among healthcare workers and stakeholders regarding NTDs. 4. Lack of resources to draft and establish guidelines to address all the NTDs and NTD pharmacovigilance issues. 5. There is no clear organogram and tasks are not well defined. 6. Lack of political will to advocate for the elimination of NTDs. 7. Inadequate research, no independent pre-and-post MDA coverage survey and impact measurement. 8. 8.Nonexistence of vector control beyond malaria 9. Inadequate government leadership of national NTD agenda 10. The gap in financial and other requirements remains huge for national NTD programmes. 11. Insufficient capacity to monitor and evaluate NTD programmes. 12. Insufficient resources for implementation remain a major obstacle to rapid scale up of interventions. 13. Weak coordination of national NTD programme 14. Lack of harmonized programme policies

	15. Poor integration of interventions
Opportunities	***Threats***
1. Existence of School health programmes jointly run by the Ministry of Education and Ministry of Health. 2. Existence of the Nutrition Council which is coordinating nutrition activities in the country. 3. Support from the partners to conduct training and draft guidelines. 4. Increased partnership and collaboration 5. Integration/Co-implementation (e.g IVM) 6. Increasing momentum to tackle NTDs. 7. The existence of the 2021-2030 NTD Road Map 8. International investments in the prevention and control of NTDs is increasing 9. Broadening collaboration with intergovernmental organizations and nongovernmental development organizations (NGDOs) 10. Collaboration with academic institutions 11. Increasing collaboration with civil society and the private sector 12. Availability of new technologies and tools, including e-health and real-time information technologies	1. High donor dependency 2. Dependency on external resources for surveillance, monitoring and evaluation. 3. Inadequate resources for implementation. 4. Drug donations are for selected groups, yet prevalence is across all ages. 5. Climate change 6. No budget line for NTDs within MoH. 7. Competing priorities in the health sector 8. Complex emergencies e.g COVID-19 pandemic

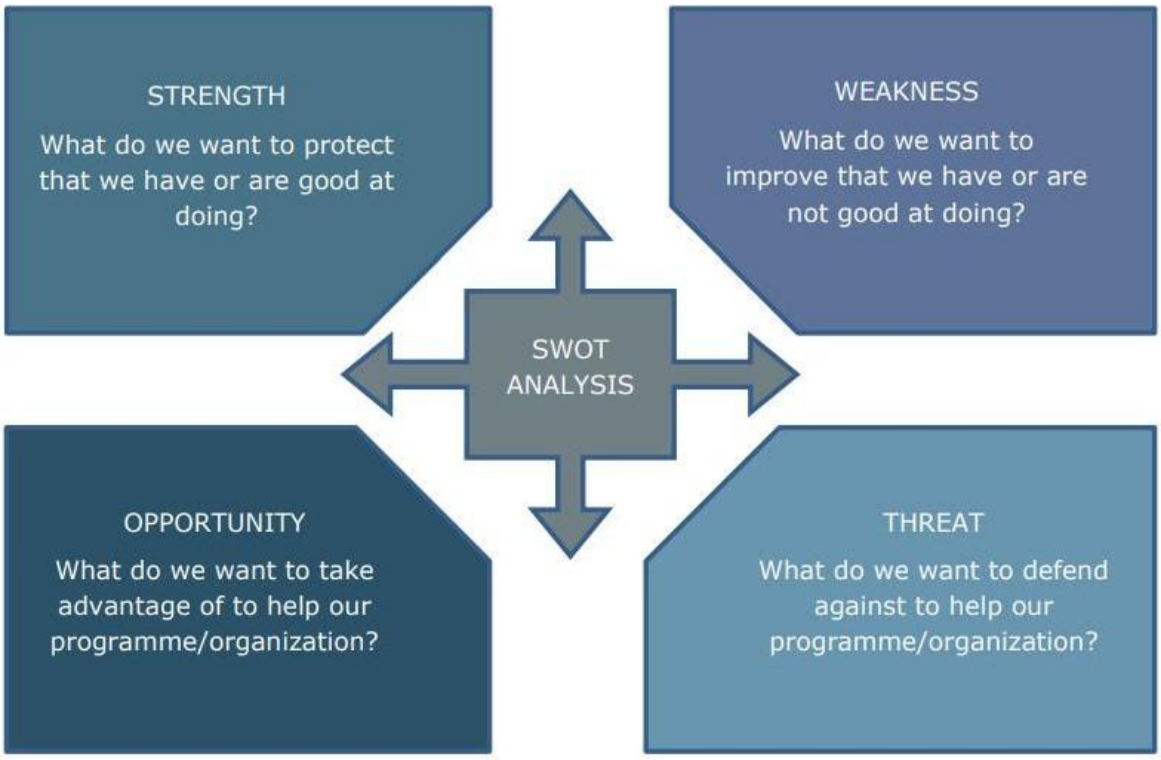

Figure 6: Swot Analysis

Strengths

The major strengths of national NTD programmes in the Eswatini include strong commitment from national government, established NTD programme in all countries that have developed integrated national multi-year strategic plans and monitoring and evaluation frameworks to tackle NTDs. In addition, countries in the Region have the experience and expertise and have eliminated leprosy as a public health problem (reduction of the prevalence rate to less than one case per 10,000 populations) at the national level in all countries since 2005. Furthermore, the Region is close to eradicating guinea-worm disease whose annual incidence has decreased by 99% since 2005 (5057 cases), with only Chad, Ethiopia and Mali remaining endemic in 2012 when only 21 cases were reported.

Weaknesses

Weak coordination of many national NTD programmes and inadequate government leadership of the national NTD agenda are major weaknesses. Furthermore, lack of harmonized programme policies, un-streamlined programme strategies, poor integration of interventions and limited technical support are issues of concern. The lack of coordination between researchers and implementers remains a major concern as is the quality of data. The geographic coverage of preventive chemotherapy is increasing for lymphatic filariasis, schistosomiasis, soil-transmitted helminthiasis and trachoma. However, treatment coverage rates for these diseases are still far below the agreed targets.

The gap in financial and other requirements remains huge for national NTD programmes, functioning within effective health education and other sectors to ensure sustained delivery of

NTD-related services and interventions. Un-streamlined funding mechanisms as well as insufficient capacity to monitor and evaluate NTD programmes are factors impeding progress towards achieving NTD elimination goals. In addition, insufficient resources for implementation remain a major obstacle to rapid scale-up of interventions.

Threats

However, competing priorities in the health sector, weak health systems, wars, insecurity and complex emergencies remain major threats to tackling NTDs in countries of the African Region. The generally low socioeconomic conditions and the dearth of resources in many countries in the African Region remain impediments to the rapid scale-up of NTD-related interventions.

Opportunities

The increasing momentum to tackle NTDs, including the commitment of Member States, the WHO NTD global roadmap and the London Declaration on NTDs, provides new opportunities to speed up the fight against NTDs. National and international investments in the prevention and control of NTDs is increasing. Other opportunities are the increasing and broadening collaboration, including the engagement of the United Nations system, intergovernmental organizations and nongovernmental development organizations (NGDOs), academic institutions, civil society and the private sector. The donations of sufficient quantities of quality-assured essential medicines for the prevention and treatment of NTDs, availability of safer medicines and diagnostics, new technologies and tools, including e-health and real-time information technologies, present new opportunities for accelerating the achievement of regional NTD goals. The increasing momentum to tackle NTDs, including the commitment of Member States, the WHO NTD global roadmap and the London Declaration on NTDs, provides new opportunities to speed up the fight against NTDs. National and international investments in prevention and control of NTDs is increasing. Other opportunities are the increasing and broadening collaboration, including the engagement of the United Nations system, intergovernmental organizations and nongovernmental development organizations (NGDOs), academic institutions, civil society and the private sector. The donations of sufficient quantities of quality-assured essential medicines for prevention and treatment of NTDs, availability of safer medicines and diagnostics, new technologies and tools, including e-health and real-time information technologies present new opportunities for accelerating the achievement of regional NTD goals.

1.5.3. Gaps and priorities

The SWOT Analysis had identified gaps and priorities which are used for the formulation of the strategic objectives to help Eswatini to achieve the 2030 goal of eliminating the targeted NTDs.

Table 8: Gaps and priorities

Gaps	Priorities
NTD programme is not fully constituted	Establish an NTD programme in Eswatini to appropriately coordinate NTD activities.
NTDs are not part of National Priorities	Mainstream NTD into the National Health System and advocate budget allocation
Limited professional disciplines in the NTD Program	Identify human resources and build capacity on NTD program activities.
Lack of pharmacovigilance for NTDs	Build capacity for Pharmacovigilance for NTDs in Eswatini. Strengthen government ownership, advocacy, coordination, and partnerships.
Lack of knowledge and skills among healthcare workers and stakeholders regarding NTDs.	NTD programme-related knowledge and skill transfer training. Improve planning for results, resource mobilization and financial sustainability of the NTD programme.
Nonexistence of operational guidelines and monitoring and evaluation tools	Develop NTD guidelines. Scale-up access to interventions, treatment and capacity building.
Limited collaboration between stakeholders in the fight against NTDs	Strengthen government ownership and coordination mechanisms
Limited commitment from all relevant stakeholders to advocate for the elimination of NTDs.	Enhance Advocacy

Gaps	Priorities
	Enhance NTD monitoring and evaluation, surveillance, operational research and share research results Enhance one health concept in the control of NTDs
Lack of research, no independent pre-and-post MDA coverage survey and impact surveys.	Provide financial resources for research, monitoring and evaluation of the NTD programme including for impact assessments.
Planning for NTD-specific disease interventions is still done in silos	Strengthen multisectoral coordination for Integrated planning Improve coordination at all levels Advocate for NTDs to be a program in the MOH
WASH and NTDs programmes are not integrated. Lack of harmonized programme policies and interventions	Strengthen coordination and multisectoral collaboration. Strengthen inter-sectoral collaboration
Partners interested in supporting NTD activities are few in Eswatini	Institute partner mapping Intensify advocacy for improved partnership
Minimal involvement of intergovernmental organizations	Advocacy for improved multi-stakeholder partnership
	Improve standardization of NTD case definitions and diagnostics
Inadequate data for NTDs	Conduct research to provide adequate data on NTDs.
Inadequate epidemiology and Laboratory-based surveillance	Build capacity in laboratory-based surveillance of NTD

Gaps	Priorities
Limited local funding for NTDs	Advocate and strengthen government ownership of the NTD programme Mainstream and improved reporting of NTDs through the National Health Information System Create a budget line for NTDs at national and regional levels
Limited Supply Chain Management System for NTD	Integrate NTD MDA and case management medicines and supplies into the MoH's routine supply chain management practices

PART 2
STRATEGIC AGENDA: PURPOSE AND GOALS

This section provides an overview of the targets and milestones for the NTDs that are public problem in Eswatini. The strategic agenda of the national NTD programme articulates the overall programme vision, mission, and goals. It also delineates the strategic goals, major programme focusses, and strategic milestones. In addition, the strategic priorities and strategic objectives indicate the main 'pillars of excellence' as well as the continuous improvement objectives that the programme seeks to achieve during the life cycle of the master plan.

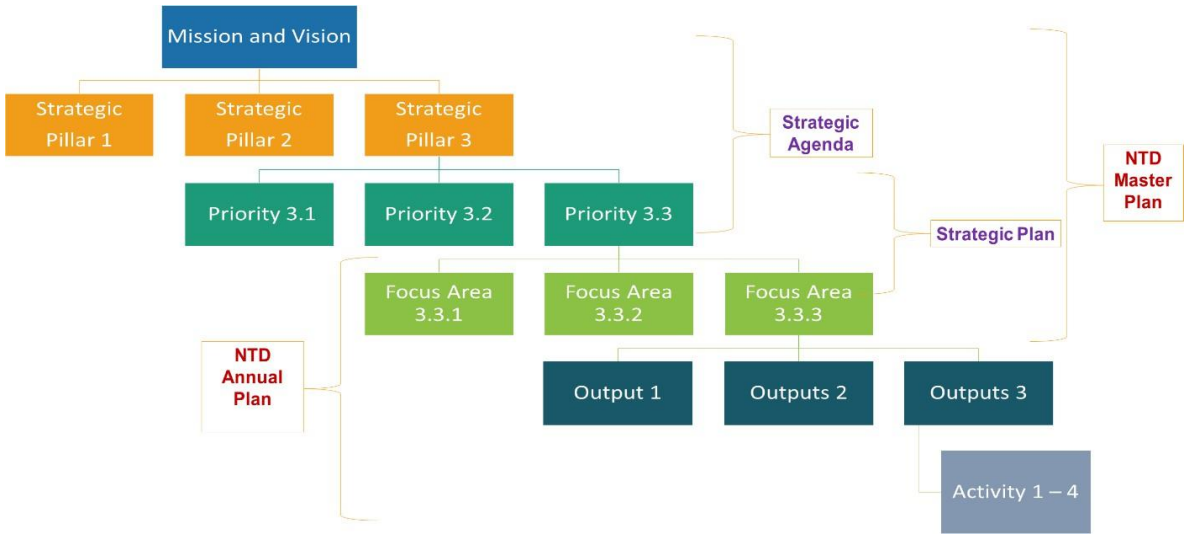

Figure 7: Hierarchy of Objectives for national NTD programmes

2.1. NTD Programme Mission and Vision

Table 9: Vision, Mission, and goals of the NTD Programme of Eswatini

Vison	**A healthy and productive Eswatini population free of NTDs**
Mission	To provide the most effective tools and services for NTDs prevention and control in an efficient and equitable client-centered manner for accelerated attainment of the highest standard of health to all people in Eswatini.
Goals	To accelerate the reduction of the disease burden by the control, elimination and eradication of targeted NTDs and contribute to poverty alleviation, productivity and quality of life of the affected people in Eswatini.

2.2: Milestones and Targets

The overarching and cross-cutting targets, derived from the NTD Global Roadmap 2021–2030 which will help in integration, coordination and country ownership and equity. Targets for sectors such as WASH, safety, and vector control can be based on established targets. Disease-specific targets for 2026 and milestones for 2024 and 2028 are set for each of the endemic diseases for one of the following: eradication, elimination (interruption of transmission), elimination (as a public health problem) or control.

Overarching targets

- 90 percent reduction in people requiring NTD interventions by 2030
- 75 percent reduction in disability-adjusted life related to NTDs by 2030
- Eliminate Leprosy and SCH by 2030

Cross-cutting Targets

The below figure shows cross-cutting targets that will guide the overall national programme-

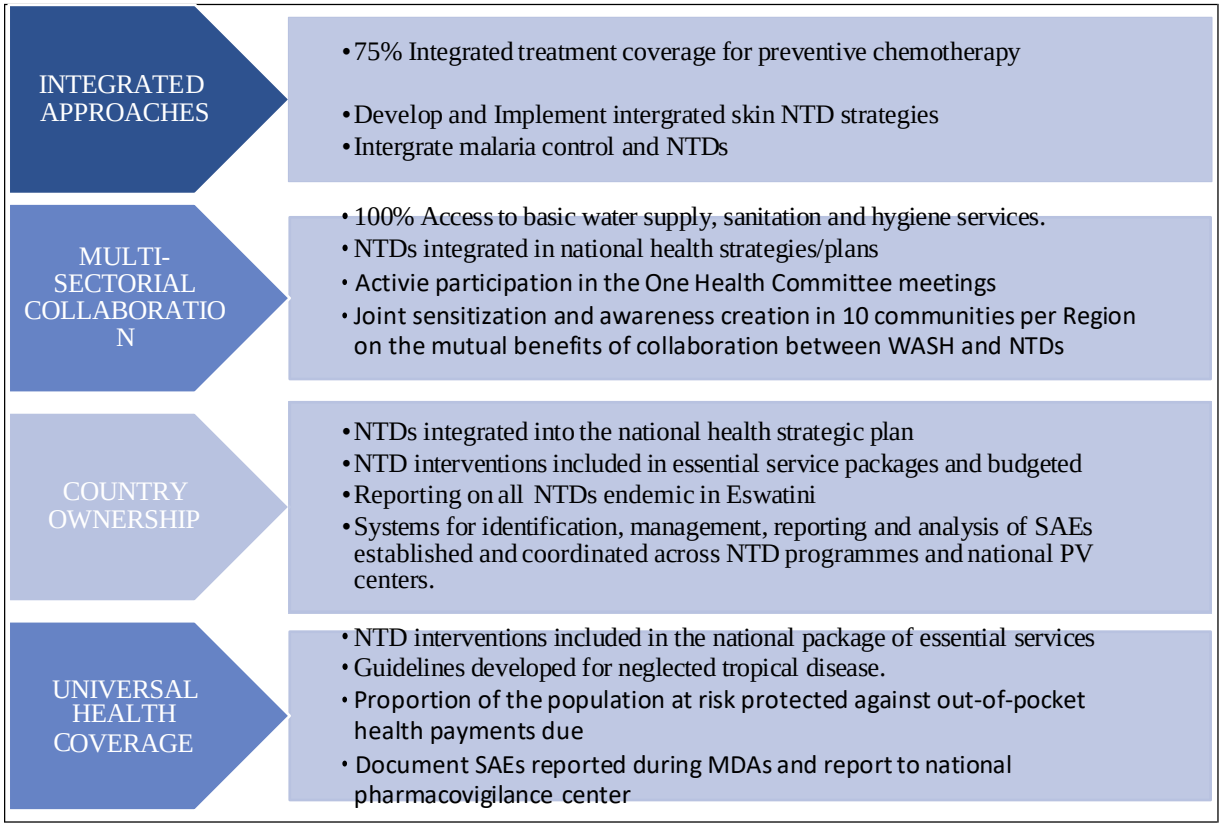

Figure 8: Cross-cutting targets

Table 4: Disease-Specific Targets

National target	Diseases	Objective	Year	Strategies
Targeted for elimination (transmission interruption)	**Leprosy**	Number of Tinkhundla with zero autochthonous leprosy	**2028**	**Sustained active case finding & single dose rifampicin for contacts**
Targeted for elimination as a public health problem	**Schistosomiasis**	To Achieve <1% proportion of heavy intensity of SCH infection To sustain 100% therapeutic coverage among all at-risk populations in endemic tinkhundla To provide PC for 100% of at-risk populations in endemic tinkhundla	**2028**	Mass drug administration, WASH improvement, public health education, snail control Integrated Vector management, community engagement and operational research, case management, improve diagnostics by use of point of care test, impact assessment
	Soil-transmitted helminths	To achieve <2%proportion of STH infection of moderate and heavy intensity	**2028**	Health Education Surveillance Improve and strengthen WASH interventions, MDA, Mapping, case management, and community engagement, and improve diagnostic capacity for test and treatment

National target	Diseases	Objective	Year	Strategies
		To contribute towards the attainment of UHC through integrated STH services in the PHC To provide continuous MDAs ensuring100% geographic and therapeutic coverage		
	Lymphatic filariasis	To be validated for elimination of LF as a public health problem	**2028**	Mass Drug Administration & Vector control, social support
	Trachoma	To be validated for elimination as a public health problem (defined as (i) a prevalence of trachomatous trichiasis "unknown to the health system" of <0.2% in ≥15-year-olds in each formerly endemic district; (ii) a prevalence of trachomatous inflammation—follicular in children aged 1–9 years of <5% in each formerly endemic	**2028**	WASH Health Education Case management MDA Surveillance

National target	Diseases	Objective	Year	Strategies
		district; and (iii) written evidence that the health system can identify and manage incident cases of trachomatous trichiasis, using defined strategies, with evidence of appropriate financial resources to implement those strategies)		
	Rabies	Achieve zero human deaths from rabies	**2028**	Post-exposure prophylaxis, dog vaccinations, morbidity management
Targeted for control	**Scabies**	Incorporated scabies management in the UHC package	**2028**	Mass drug administration IDM
	Snakebite envenoming	Achieving a reduction of mortality by 50%	**2028**	Provision of antivenom to all health facilities, morbidity management, and public health education for early treatment-seeking
	Taeniasis and Cysticercosis	To increase to 100% the number of endemic Tinkhundla with Intensified control	**2028**	**MDA, Health Education, Case management, Surveillance Vaccination/treatment of pigs (one health concept)**
	Foodborne trematodes	Number of endemic Tinkhundla with intensified control	**2028**	Implementing preventive chemotherapy (MDA), Health Education, Case management, Surveillance

2.2.2. National Milestones for targeted NTDs

To ensure that interventions are being implemented for each targeted PC and CM NTD endemic in Eswatini, several milestones have been developed indicating the scaling up and scaling down of interventions.

Table 5.0: Schistosomiasis Milestones

Indicators	2024	2025	2026	2027	2028
Achieved 100% geographical coverage for MDA in SCH endemic tinkhundla	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Number of tinkhundla that have conducted 3-5 years of consecutive treatments with population coverage **more than 75%**		59 (100%)	59 (100%)	59 (100%)	59 (100%)
Conducted annual sentinel sites survey in at least 100% of selected sites of SCH endemic tinkhundla.		24 (100%)	24 (100%)	24 (100%)	24 (100%)
Impact assessment survey for schistosomiasis conducted after 5 years of successive annual MDA					59 (100%)
Endemic tinkhundla achieved elimination as a public health problem			27 (46%)	44 (75%)	59 (100%)

Table 12.1: STH Milestones

Indicators	2024	2025	2026	2027	2028
Achieved 100% geographical coverage for MDA in STH endemic tinkhundla	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Conducted 5 years of consecutive treatments (MDA) in all endemic tinkhundla with population coverage more than 75%	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Conducted annual sentinel sites survey in at least 100% of selected sites of STH endemic tinkhundla.		24 (100%)		24 (100%)	24 (100%)
Conducted impact assessment survey in 100% of STH endemic tinkhundla					59 (100%)
Endemic tinkhundla achieved elimination as a public health problem		27 (46%)	30 (50%)	44 (75%)	59 (100%)

Table 12.3: Milestones for LF

Indicators	24	2025	2026	2027	2028
Completed mapping of LF and determined LF endemic areas and the population at risk in all Tinkhundla in Eswatini	59 (100%)				
Begun implement LF MDA in IUs requiring LF MDA	100%	100%	100%	100%	100%
Achieve 100% geographical coverage of LF MDAs in endemic Tinkhundla	100%	100%	100%	100%	100%
Number of Tinkhundla conducted 5 rounds of MDA with coverage more than 65%					59 (100%)
Number of Tinkhundla conducted first TAS activities after at least 5 rounds of MDA among those declared endemic.			30 (51%)	40 (68%)	59 (100%)
Number of Tinkhundla conducted and passed at least 2 TAS activities.				59 (100%)	59 (100%)
Started passive surveillance & vector control activities in at least 100% of Tinkhundla					100%
Prepare and present "the dossier" for in country validation of absence of LF transmission					1 (100%)
Proportion and number of Tinkhundla where there is full coverage of morbidity-management services and access to basic care	15 (25%)	30 (51%)	45 (76%)	50(85%)	59 (100%)
Proportion and number of IUs where 75% of hydrocele cases benefitted from appropriate surgery		15(25%)	50 (85%)	59(100%)	59(100%)

Table 12.4: Trachoma Milestones

Indicators	2024	2025	2026	2027	2028
Completed mapping of trachoma	59 (100%)				
Achieved 100% MDA geographical coverage in Trachoma endemic tinkhundla	(100%)	(100%)	(100%)	(100%)	(100%)
Conducted MDA achieving at least 80% of epidemiological coverage in endemic tinkhundla	(100%)	(100%)	(100%)	(100%)	(100%)
Conducted impact assessment activities in 100% of trachoma endemic tinkhundla after the stipulated number of cycles based on prevalence		(100%)	(100%)	(100%)	(100%)
Prepare and present "dossier" for in country validation for elimination as a public health problem					1 (100%)
Validated for elimination as a public health problem, defined as i) a prevalence of trachomatous inflammation in children aged 1-9 years of less than 5%, ii)prevalence of trachomatous trichiasis unknown to the health system of less than 0.2% and iii) written evidence that the health system is able to identify and managed in incident cases of trachomatous trichiasis using defined strategies with evidence of appropriate financial resources to implement those strategies					1 (100%)

Table 12.5: Leprosy Milstones					
Indicators	**2024**	**2025**	**2026**	**2027**	**2028**
Achieved active case detection of leprosy in all endemic tinkhundla	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Achieved passive case detection of leprosy in 100% of all tinkhundla	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Managed all leprosy cases in peripheral health facilities	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Achieved 100% treatment coverage of identified leprosy cases	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Prepared and presented "dossier" for in-country verification for elimination of leprosy (transmission interruption)					59 (100%)
Achieved elimination of leprosy					59 (100%)

Table 12.6: Milestone for rabies elimination

Rabies					
Ensure timely access to post-exposure prophylaxis rabies vaccine	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Availability of post-exposure prophylaxis in health facilities	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Mass dog vaccination for rabies for at least 70% of dogs	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Wound management for dog bites	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Build national capacity of health workers for rabies exposure assessment, diagnosis, administration of post-exposure prophylaxis, for dog prophylaxis management and mass dog vaccination.	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Achieving zero death from rabies	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)

Table 12.7: Milestones for Snake bites and envenoming

Snakebite envenoming					
Proportion of notified snakebites in all health facilities	(100%)	(100%)	100%)	100%)	100%)
Availability of polyvalent anti-venom at hospitals and health centres	59 (100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)
Availability of case management services at hospitals and health centres	59(100%)	59 (100%)	59 (100%)	59 (100%)	59 (100%)

Table 6: Milestones for Scabies

Indicators	**2024**	**2025**	**2026**	**2027**	**2028**
Mapping to identify the burden of disease and endemic areas	59 (100%)				
Incorporation of scabies management in the minimum package of care	1(100%)				
Conduct case management for all cases		59(100%)	59 (100%)	59 (100%)	59 (100%)
Number of Tinkhundla where community engagement activities on Scabies are implemented	30 (51%)	50 (85%)	59 (100%)	59 (100%)	59 (100)
Establish surveillance for scabies	25 (42%)	50 (85%)	50 (85%)	59 (100%)	59 (100%)
Established capacity for case management of scabies in all health facilities	25 (42%)	50 (85%)	59(100%)	59 (100%)	59 (100%)

Table 7: PHASE Milestones

Table 12.9: PHASE Milestones					
Indicators	**2024**	**2025**	**2026**	**2027**	**2028**
The proportion of tinkhundla receiving integrated MDA with a coverage of at least 75%	30 (51%)	35 (59%)	40(68%)	59 (100%)	59 (100%)
Proportion of tinkhundla receiving appropriate health education on NTDs	30 (51%)	35 (59%)	40(68%)	59 (100%)	59 (100%)
Proportion of endemic tinkhundla with adequate access to clean water supply	10 (17%)	30 (51%)	40 (%)	50 (68%)	59 (100%)
Proportion of endemic tinkhundla with adequate sanitation	10 (17%)	30 (51%)	40 (%)	50 (68%)	59 (100%)
Proportion of endemic tinkhundla with adequate environmental manipulation	10 (17%)	30 (51%)	40 (%)	50 (68%)	59 (100%)

Section 2.3: Guiding Principles

A few guiding principles have been identified as core to the coordination framework to enable the achievement of the national goals of the NTD programme:

Table 8: Guiding principles

Guiding principles	• National leadership and ownership, • Commitment to multi-sectoral collaboration and sharing, • Mutual accountability of national authorities and partners, Transparency, and accountability, • Community engagement and participation • Safety: 'Not harm' while providing health benefits • Evident informed priority implementation • Sustainable and Efficient Interventions
Guiding Principles are a broad philosophy that encompasses Eswatini's beliefs and values and guide the programme throughout its life in all circumstances, irrespective of changes in its goals, strategies or type of work. They create a programme culture where everyone understands what's important.	

Section 2.4: Strategic Pillars and Strategic Objectives

2.4.1. Programme Strategic Pillars

Strategic Pillars for the successful implementation of the NTD programme in Eswatini are shown figure 9 below.

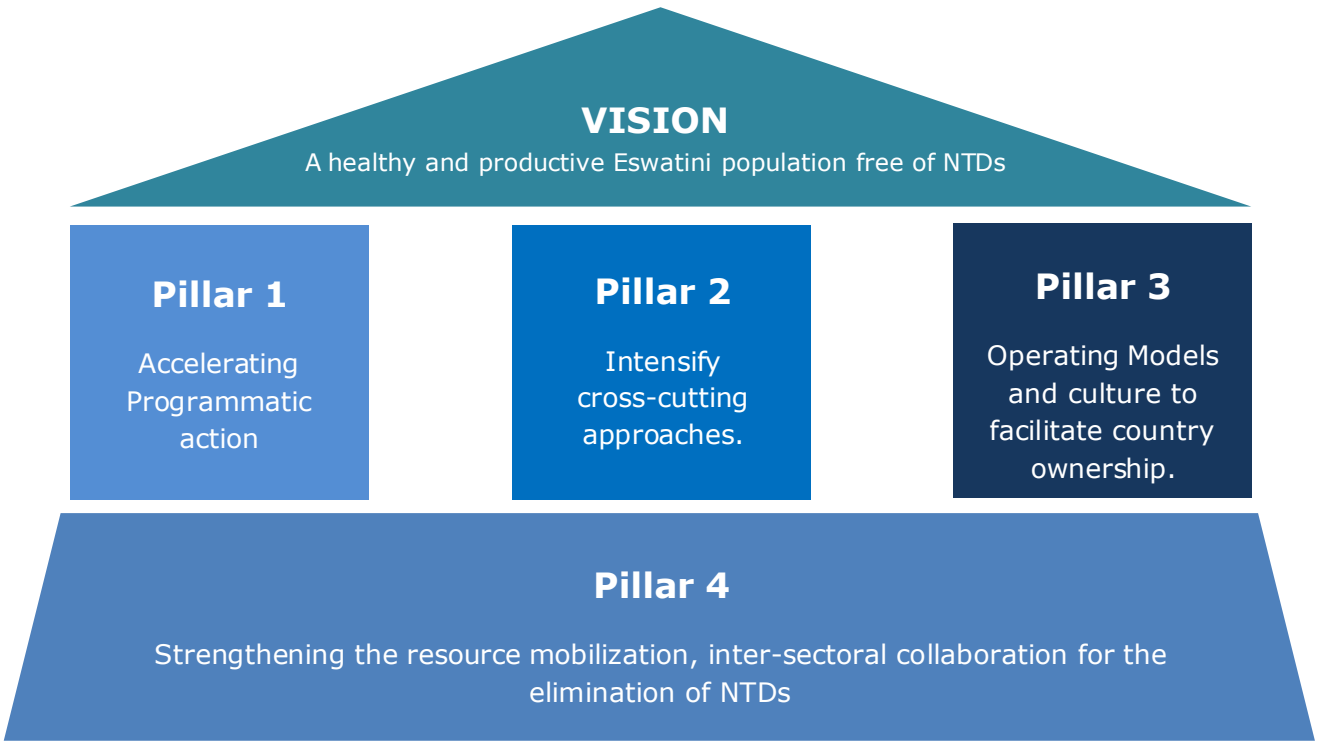

Figure 93: Programme Strategic Pillars

2.4.2. Strategic Priorities

Strategic priorities are the big-picture objectives for Eswatini's NTD programme. They describe what the programme will do to try to fulfil its mission.

Table 14: Strategic Priorities for the Elimination of Neglected Tropical Diseases in Eswatini, 2024 to 2028

Strategic Pillar	Strategic priorities
Pillar 1. Accelerating programmatic action	1. Make available epidemiological data that is systematically collected to ensure accurate determination of NTD endemicity and estimation of the population requiring interventions.
	2. Establish a functional NTD programme
	3. Integrate across NTDs: Joint delivery of interventions that are common to several diseases. 4. Integrated preventive chemotherapy to maintain 100% geographic coverage, scale down PCT where applicable and achieve the minimum disease-specific treatment coverage level of threshold.
	5. Ensure early detection and prompt treatment of targeted case management NTDs
	6. Ensure integrated planning and implementation of intervention strategies among NTD with similar intervention approaches increased efficiency and cost-effectiveness.
	7. Prioritize and strengthen monitoring and evaluation for tracking progress in line with the 2030 NTD Road map and SDGs
	8. Identify and prioritize operational research areas to facilitate NTD implementation
	9. Provide equity in access and logistics to quality-assured NTD medicines in endemic areas and to the hard-to-reach populations.
	10. Implement integrated IVM for SCH, LF and malaria
	11. Improve advocacy, and domestic funding and strengthen multi-sectoral action on NTDs.
Pillar 2. Intensify cross-cutting approaches	1. Mainstream NTD within National Health systems to improve the quality of NTD management in the context of Universal Health Coverage. 2. Strengthen and mainstream platforms with similar delivery strategies and interventions (MDAs, IVM, Morbidity management, social mobilization for Behaviour Change and Communication, WASH etc) for integrated approaches across NTDs
	3. Strengthen the national supply management system to ensure a timely, safe, and effective supply of quality-assured NTD products and medicines
	4. Integrated NTD planning, implementation, and monitoring

Strategic Pillar	Strategic priorities
	5. Strengthen multi-sectoral coordination with other sectors within and beyond health on NTDs-related interventions and response (WASH, One Health, Education, Finance, Agriculture, Ministry of Water and Land, etc.)
Pillar 3. Operating Models and culture to facilitate country ownership	1. Strengthen country ownership and leadership at all levels and ensure allocation of domestic funding for the NTD program
	2. Establish a functionally distinct NTD Unit with the Director who coordinates centralized NTD programmes and reports to higher authorities to improve the visibility of NTDs in a similar way as other health programmes like malaria, and HIV/AIDS are recognised.
	3. Put in place clear stakeholder roles throughout NTD work.
	4. Empower local capacity for social mobilization, communication and building support for NTD interventions
	5. Strengthen collaboration with other sectors (WASH, Environment, Education, Community organizations)
	6. Ensure the inclusion of NTDs into the MoH Essential Health Care Package
SP4: Strengthening Resource Mobilization, Coordination and Inter-Sectoral Collaboration for the Elimination of NTDs	1. Advocate for domestic resource allocation
	2. Promote community involvement and ownership of the program for optimal use of available resources
	3. Promote partnership and coordination in NTD programme implementation
	4. Build NTD programme capacity for resource mobilization
	5. Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.

2.4.3 Programme Strategic Agenda Logic Map

The below figure maps out logically how the programme is working and how it is inter-related.

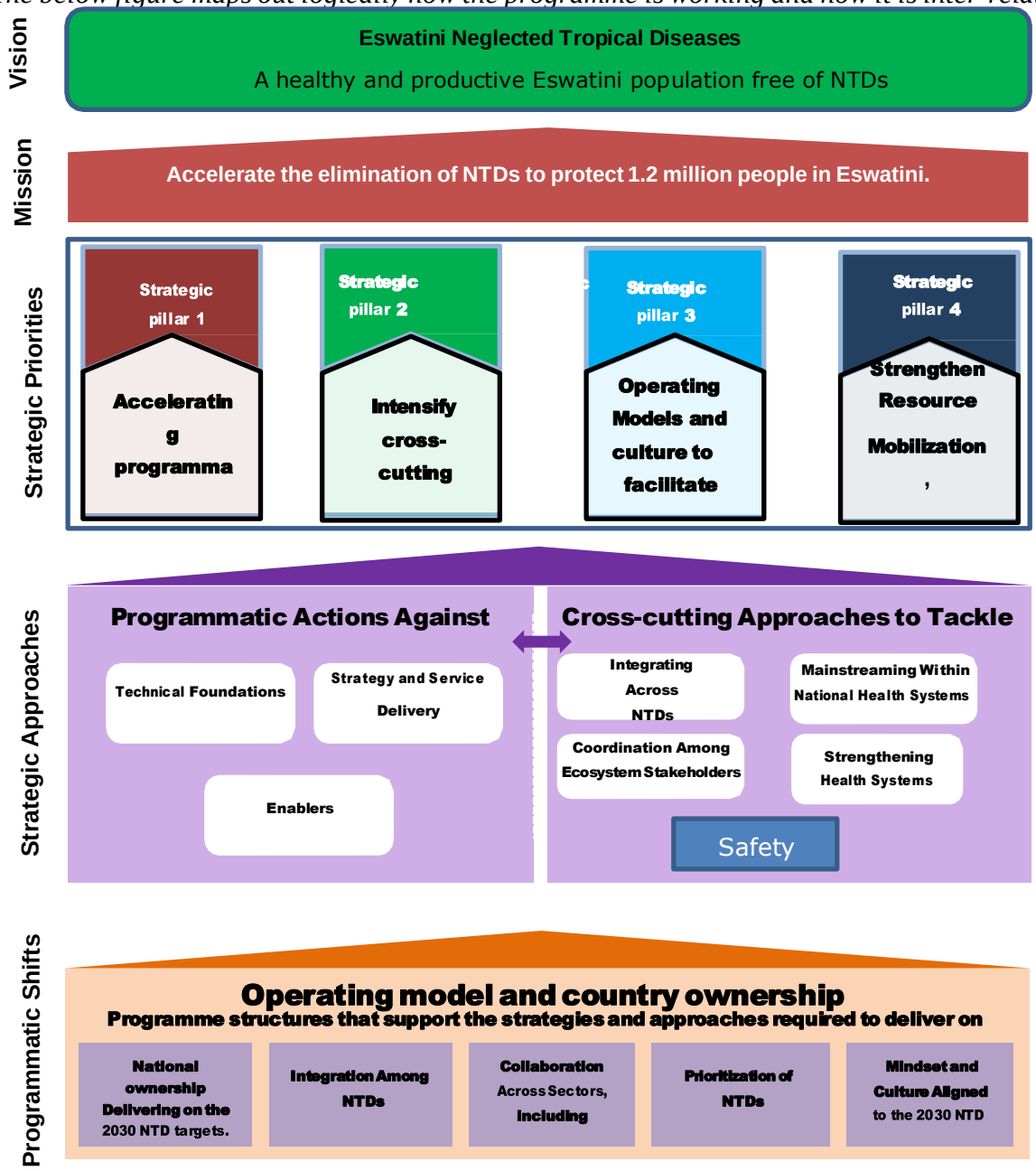

Figure 10: Programme Strategic Agenda Logic Map

Part 3: Implementing the Strategy: NTD Operational Framework

In line with the 2021- 2030 NTD Global Roadmap, this strategic plan is geared towards ensuring three fundamental shifts in the approach to tackling NTDs: **first**, increase accountability for impact by using impact indicators instead of process indicators, as reflected by the targets and milestones in Part II and accelerate programmatic action; **secondly**, move away from siloed, disease-specific programmes by mainstreaming programmes into national health systems and intensifying cross-cutting approaches centred on the needs of people and communities: and **thirdly**, change operating models and culture to facilitate greater ownership of programmes by Eswatini.

Section 3.1: Strategic priorities and Key Activities			
Table 15: Strategic Pillar 1 - Accelerating programmatic action			
Strategic Priorities	**Key Activities**	**Time frame**	**Resources needed**
Strategic Priority 1: Establish an NTD programme for efficient coordination of NTD activities	Create a fully functional NTD program with a dedicated Unit withing the Ministry of Health to be coordinated by a dedicated coordinator/Director with supporting staff made up of disease specific experts, finace person, IT officer, secretary/executive assistant and a driver	2024	**Human, Office space, financial and material Resources.**
	Develop terms of references for the NTD Programme secretariate	2024	**HR**
	Procure office equipment, materials, and vehicles	2024	**Financial resources**
Strategic priority 2: *Integrated preventive chemotherapy to maintain 100% geographic coverage, scale down PC intervention where applicable and achieve the minimum disease specific treatment coverage level for SCH, LF and STH.*	Implement MDA for SCH in all tinkhundla (#59)	Annually 2024-2028	**HR, Financial resources, medicines, supplies (stationary, measuring tape, etc.), vehicles**
	Conduct mapping of LF and estimate population requiring interventions	2025	**HR, taeniasis mapping experts, transport, financial resources, diagnostic tools**
	Conduct MDA for LF in targeted Tinkhundla	Annually 2025 -2028	**HR, Financial resources, medicines, supplies (stationary), vehicles,**
	Conduct Social mobilization and BCC	Annually 2024- 2028	**IEC materials (posters, leaflets, Billboard, conference cost, funding**
	Conduct MDA for scabies where applicable	Annually 2024-2028	**HR, Financial resources, medicines, supplies (stationary, measuring tape, etc.), vehicles**
	Conduct mapping for trachoma to determine the population requiring interventions	2024	**HR, trachoma mapping experts, transport, financial resources, diagnostic tools**

	Conduct MDA for trachoma in endemic Tinkhundla	2025	**HR, Financial resources, medicines, supplies (stationary, measuring tape, etc.), vehicles**
	Conduct mapping to determine endemicity of taeniasis and to estimate population requiring intervention	2025	**HR, taeniasis mapping experts, transport, financial resources, diagnostic tools**
Strategic priority 2: ***Ensure early detection and prompt treatment of targeted case management NTDs***	Strengthen Institutional capacity building for laboratory services'	2024	**Conference facilities, transport, fuel, requisite HR, Reagants**
	Conduct burden assessment for Scabies and Rabies	2024	**Funding, experts, tools, supplies, transportation,**
	Build capacity of HCWs on case management, morbidity management and disability prevention	Annually 2024-2028	**HR, funding, development of guidelines and manuals, stationery,**
	Build capacity of HCWs, communities and teachers on NTDs	Annually 2024-2028	**HR, funding, guidelines and manuals, stationery,**
	Build national capacity for timely detection and response for outbreak prone NTDs – surveillance training	Annually 2024-2028	**Expert, supplies (diagnostic kits, medicines), funding, transportation, tools (Rapid assessment guideline, etc), stationary materials,**
	Ordering medicines and diagnostic kits for CM NTDs	Annually 2024-2028	**Expert, funding, commodities**
	Train on the use of JAP in estimating and joint requesting medicines Quantification and request for the procurement of supplies for PC NTDs (medicines, diagnostic kits)	2024	**Expert, funding, commodities**
	Develop guidelines and manuals for NTDs	2024	**Expert, funding, supplies, transportation, infrastructure,**
Strategic priority 3: Prioritize and strengthen monitoring and	Develop M&E framework	2024	NTD expert for technical assistance, HR, Funding

evaluation for tracking progress in line with the 2030 NTD Road map and SDGs	Distribute the M&E framework across all levels of data collection	2024	HR, Electronic Health information system
	Conduct confirmatory mapping LF	2024	Expert, ICT, funding, transportation, tools
	Conduct mid-term review and evaluation of NTDs master plan.	2026	Technical support, funding, HR
	Conduct SCH impact assessment	2025, 2027	Expert, supplies, funding, transportation, IEC
	Conduct STH impact assessment	2025, 2027	Expert, supplies, funding, transportation, IEC
	Establish and monitor sentinel sites for surveillance of SCH and STH	Annually	Expert, tools, funding, transportation
	Conduct a baseline survey burden for CM NTDs	2024	Guidelines and tools, funding, transportation, kits and medicines, experts
	Prepare and submit dossier for the elimination of LF	2028	National documents and reports, experts, transportation, HR, funding, stationary materials,
	Strengthen national HMIS-Integration. of NTDs variable/ development of NTD Modules	2024	Expert, funding, IT equipment, tools/manuals,
Strategic priority4: ***Identify and prioritize operational research to facilitate NTD implementation***	Consult experts and build consensus on priority research areas for NTDs (KAP, sentinel sites, uptake coverage, impact assessment, drug efficacy studies)	Annual	Expert, HR, funding, venue
	Conduct research to assess the burden of female genital schistosomiasis (FGS) and document	2025-2026	Expert, HR, Funding, transport
	Carry out Pharmacovigilance assessment/testing of the safety of the medicines	Annual 2024-2028	Experts, HR, Transport, funding

	Build institutional capacity to conduct research	2026	Expert, venue, funding
	Publish and disseminate research results	Annually 2024-2028	HR (experts, prog managers, policy maker, venue, funding, stationary
Strategic Pillar 2: **Intensify cross-cutting approaches**			
Strategic Priority: ***Strengthen and mainstream platforms with similar delivery strategies and interventions (MDAs, Morbidity management, social mobilization for Behaviour Change and Communication, WASH, IVM, EPI, MCH services, etc) for integrated approaches across NTDs***	Train healthcare workers and other stakeholders on integrated vector management guideline.	2024	HR, Technical expert, Funding
	Procure integrated vector management chemicals, PPEs, and equipment	2025	Funding, HR
	Conduct Integrated delivery of service for NTDs and (EPI, MCH, nutrition, TB, Malaria)	Annually 2024-2028	Advocacy and consensus building, HR, funding, tools, transportation, medicines, kits
	Conduct integrated vector management for vector borne NTDs (SCH, LF) and other vector borne diseases such as malaria	Annually 2024-2028	Supplies (ITN, IRS, larviciding chemical and molluscides), funding, experts, transport, IEC, guidelines
	Conduct integrated MDA for SCH, STH, LF	Annually 2024-2028	Guidelines and manuals, HR, funding, medicines, SAE reporting tool, tools, transport, IEC material
	Integrate with WASH/Environmental Health	Annual 2024-2028	Expert, funding, transport, IEC material,
	Capacity building on provision of integrated services (IVM Training)	2024 -2025	Expert, funding, guidelines and manuals, venue, stationery
	Monitoring and evaluation of the program activities-Develop the NTD M&E Framework	2024	Expert, funding, data collection tools, computers, phone and airtime, transport
Strategic Priority: ***Strengthen national supply chain management***	Advocacy for wavering free importation of donated medicines and supplies	Annual 2024-2028	National Policy, HR

systems to ensure timely, safe, and effective supply of quality assured NTD products and medicines	Improve infrastructure-renovation of the office	2024-2028	Funding, IT materials, HR
	Build Capacity for timely delivery of supplies to IU level, monitor stock, improve reverse logistics – Supply chain management, to be included in health care workers training	Bi-annual 2024-2028	experts, HR, Transport, funding, (conference), Storage place, logistic management information system
Strategic Priority*: Integrated NTD planning, implementation, and monitoring*	Conduct annual programme review and stakeholders' meetings	Annua1ly 2024-2028	Funding, venue, transport, HR, stationery,
	Conduct Quantification, application, and procurement of supplies for CM NTDS	Annually 2024-2028	HR, tools, transport
	Conduct supportive supervision	Quarterly 2024-2028	Experts, tools, funding, transport
	Participate in international meetings	Annually 2024-2028	HR, Funding, conference facilities
Strategic Priority*: Strengthen multi-sectoral coordination and response (WASH, One Health, Ministry of Education, Finance, Agriculture, Water and Land, etc.)*	Strengthen coordination mechanism	Annually 2024-2028	HR, TORs, funding
	Establish the NTD technical working group	2024	Funding, conference, HR, transport
	Conduct Regular planning and review meetings	Quarterly 2024-2028	Funding, experts, programme reports, venue, transportation
	Develop a multisectoral strategic plan	2025	Experts, guidelines, tools, funding
Strategic Pillar 3. Operating Models and culture to facilitate country ownership			
Strategic Priority: ***Strengthen country program ownership and leadership at all levels***	Advocate for domestic funding	Annually 2024-2028	Advocacy tools, experts, funding, venue, stationary, IEC materials, transportation
	Improve community involvement	Annually 2024-2028	IEC, community leaders, experts, funding, transport, venue
	Advocate for Gender, **equity,** and human rights (GER) agenda	Annually 2024-2028	Experts, funding, venue, transport, monitoring tools

	Advocate for Inclusion of NTDs in the National Health Sector Strategic Plan	2024	HR, experts, transport
	Support NTD service provision at Primary Health Care (Universal Health Care)	Quarterly 2024-2028	National Health Policy, HR, funding tools, guidelines, transport
	Advocate for Inclusion of NTD indicators in national HMIS	2024	Tools (disease-specific indicators, HMIS), existing NHP, HR, experts, IT, funding
Strategic Priority*:* ***Empower local capacity for social mobilization, communication and building support for NTD interventions***	Conduct community engagement and communication	Annually 2024-2028	IEC materials, Experts, funding, transport
	Build capacity for resource mobilization	Annually 2024-2028	Funding, transport, experts
	Promote Involvement of all community groups (swimmers, fishermen, farmers, business, etc)	Annually 2024-2028	Experts, funding, Autotransporter, venue, shelter structures, gazebo, promotional materials, public address system
Strategic Priority: ***Strengthen collaboration with other sectors (WASH, Environment, Education, Community organizations)***	Strengthen coordination mechanisms among various sectors	Quarterly 2024-2028	SOP, HR, venue, stationary, funding
	Promote integrated service provision	2025	National strategy, HR
	Involvement of the community in NTD interventions	Annually 2024-2028	IEC, stationary, funding vehicle, airtime, smartphone
Strategic Pillar 4. Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs			
Strategic Priority: ***Build NTD programme capacity for resource mobilization***	Conduct Mapping of potential donors	2025	Experts, funding
	Conduct NTD Programme Review – Restructuring of the programme itself	Review in 2026 and end-term review is 2028	HR, funding, conference costs
Strategic Priority*:* ***Promote partnership and coordination for NTD programme implementation***	Identify NTD stakeholders (internal, external)	2024	HR
	Strengthen and promote multisectoral coordination	Quarterly 2024-2028	HR, venue, stationery, funding

	Commemorate the World NTD Day	Annually	IEC material, HR, funding
Strategic Priority: ***Advocate for domestic resource allocation***	Development of IEC material	Biannual 2024-2028	IEC, stationery, funding, Experts
	Conduct an advocacy for policymakers	Annually 2024-2028	IEC, HR, funding, conference costs
	Identify NTD Ambassadors and champions (public figures for advocacy on NTDs)	**2025**	Transport, Experts, funding

Section 3.2: Toward NTD Programme Sustainability: Intensifying Coordination and Partnerships

NTD Programme Partnership and Coordination Mechanism

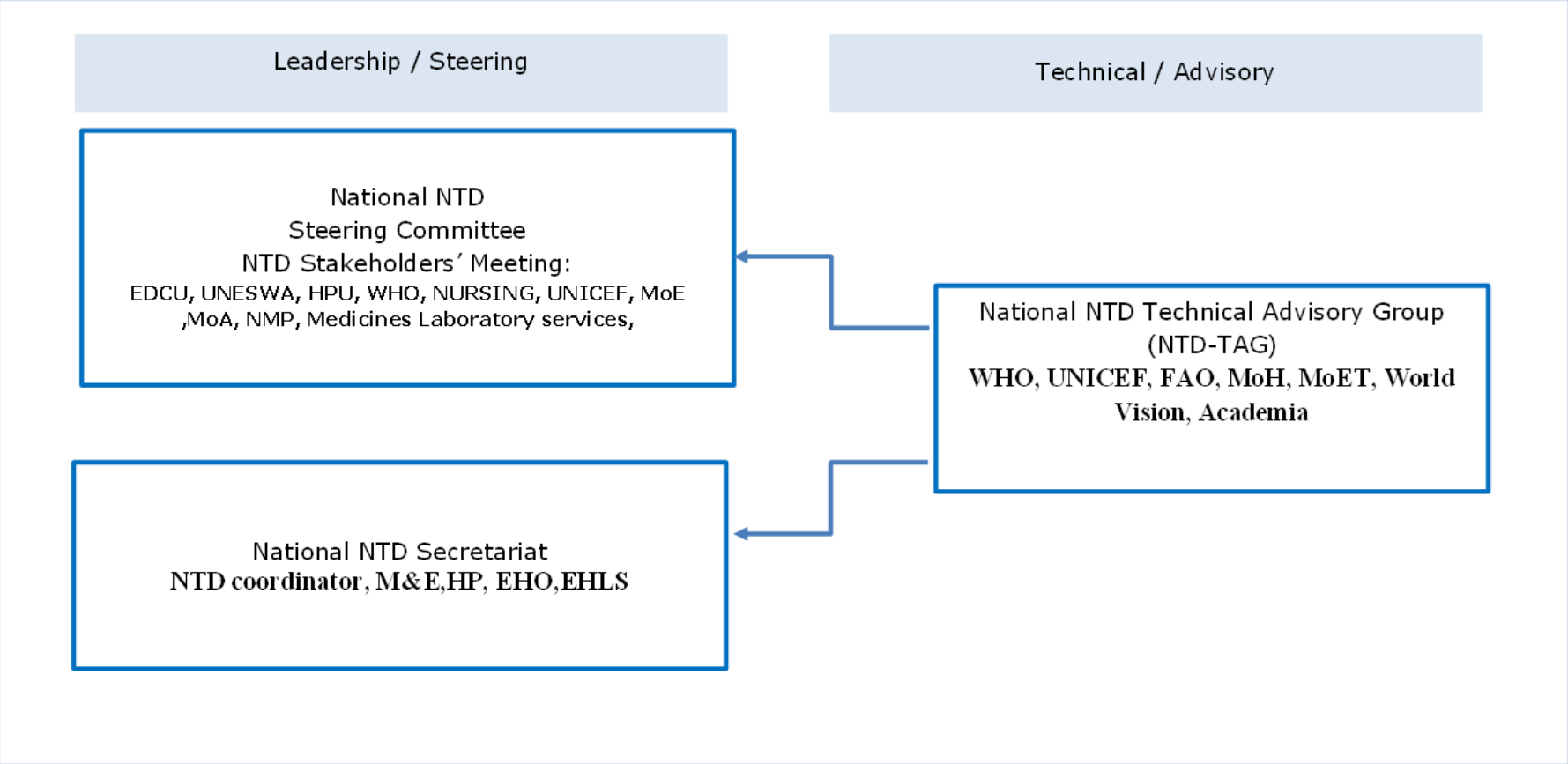

Figure 4: Programme coordination mechanism

Entity	Membership	Terms of Reference
National NTD Steering Committee (Policy makers)		
Meeting frequency: Bi-annually **Chair**: Director of Health Services **Host**: NTD Program	**NMP, EDCU, UNESWA, HPU, WHO, NURSING, UNICEF, MoE MoA, Medicines Laboratory services,**	1. The committee serves as an advisory body to the MoH. 2. Monitor and evaluate the implementation of the masterplan. 3. Review implementation plan. 4. Advocate for resource mobilisation and political awareness. 5. Advocate for improved visibility of the NTD programme 6. To perform any other duties related to or incidental to NTDs elimination.
National NTD Secretariat (NTD coordinator, M&E, HP, EHO, EHLS)		
Meeting frequency: Quartely **Chair**: NTD Coordinator **Host**: MOH	NTD coordinator, M&E, HP, EHO, EHLS, Finance officer,Secretary, driver, Programme Officers (Leprosy, Trachoma, STH & SCH, Rabies, Mycetoma & other Skin Diseases, Snakebite)	1.Being a secretary to the steering committee and National Advisory group 2.Scheduling meetings 3.Coordinating the implementation of services 4.Compiling of reports 5. Maintain accurate dossier on each NTD disease 6. Administer the day to day NTD programme activities and coordinate all partners/stakeholders' inputs 7. To perform any other duties related to or incidental to NTDs elimination
National NTD Technical Advisory Group (Experts)		
Meeting frequency: Once annually **Chair**:TBD **Host**: MOH	WHO, UNICEF, FAO, MoH, MoET, World Vision, Academia	1. Review individual progress of each disease 2. Advisory board to the NTD Program 2.To advise the steering committee and the secretariat

		3. They monitor the implementation of the NTD Masterplan 4. Mapping of potential donors and partners 5. To perform any other duties related to or incidental to NTDs elimination 6. Advise on technical issues regarding NTD programme implementation 7. Provide current information of disease specific direction.
Regional NTD Secretariat		
Meeting frequency: Chair: Host:	For Eswatini the Regional Secretary does not apply, because the country is small for it to have regional offices.	N/A
Fig 12. Membership and Terms of Reference – Programme Coordination Mechanism		

Partnership Matrix

This section provides the partners in Eswatini including the implementing partners, donors, private and public partnership, such as Ministry of Agriculture, Ministry of Education, Pharmacovigilance Center, or thematic partners such as One-Health partners or specific donors.

Table 16: Partnership Matrix

State	NTDs (List)	Veterinary (List)	WASH (List)	IVM (List)	One-Health (List)	Education (List)	Malaria (List)
Eswatini	MoH	Ministry of agriculture	World vision	MoH	MoH	MoH	WHO
	MoET	Environment	Environmental health/MoH	MoA	MoA	UNICEF	MoH
	MoA	MoH	MoET	WHO	Ministry of Works	MoET	MoA
	Environment and tourism	MoET/University	MoNR	Eswatini Environmental Authority	WHO	UNESWA	Tourism
	MoNR		WHO	UNESWA	EEA	Ministry of Tinkhundla	UNESWA
	Ministry of Tinkhundla		UNICEF		CDC/PEPFA	Correctional Services	
	WHO		ESWADE				
			Water Aid				

3.3: Assumptions, Risks and Mitigations

An assessment was made to determine how likely the risks will arise during the implementation of the 2024-2028Eswatini Master Plan. The impact of the identified risks on the programme outcomes and objectives was also focused in terms of time schedule, quality and cost (Table 17). To mitigate the risks, options and actions to enhance opportunities and reduce threats to the programme objectives were developed. To cater for any new risks risk mitigation progress monitoring including tracking identifiable risks, identifying new risks and evaluating risk process effectiveness throughout the programme period will be undertaken.

Table 17. Risk Criteria and Assessment							
Potential risk	**Before Risk Mitigation**			**Risk Mitigation**			
	Likelihood of occurrence	**Impact**	**Score**		**Likelihood of occurrence**	**Impact**	**Score**
			Likelihood x impact				**Likelihood x impact**
	Certain =5	Severe=5			Certain =5	Severe=5	
	Likely =4	Major=4			Likely =4	Major=4	
	Possible =3	Moderate =3			Possible =3	Moderate =3	
	Unlikely =2	Minor=2			Unlikely =2	Minor=2	
	Rare =1	Insignificant=1			Rare =1	Insignificant=1	

Risk type							
COVID19 and other pandemics	4	3	12	COVID19 prevention	3	3	9
Emerging and re-emerging disease outbreaks	3	4	12	Repid response preparedness for mitigation	3	2	6
Lack of Funding	5	5	25	Advocacy for funding and mainstreaming	3	3	9
Life threatening cyclones	4	5	20	Repid response preparedness for mitigation	4	3	12
Weak coordination	4	4	16	Coordination mechanism	1	3	3
Migration of trained and experienced health workerforce	4	5	20	Improvement of conditions of service and recruitment of health workers	2	2	4
Community fatigue to multiple rounds of MDAs	3	4	12	Community Engagement to address misconceptions NTDs	1	2	2

Vectorial insecticide resistence (Indoor residual spraying insecticide for mosquitoes)	3	4	12	Research for new efficiacious and affordable insecticides	1	1	1
Operating in silos	4	4	16	Strengthen country ownership of the NTD prgramme, mainstream NTD into the National Health System, strengthen coordinayion of the NTD at all levelks, including partners interested in the NTD programme and enhance intersectoral collaboration	1	1	1

Risk Rating (Likelihood x Impact)	
19-25	Severe
13-18	Major
7-12	Moderate
0-6	Minor

Fig 11. Membership and Terms of Reference – Programme Coordination Mechanism

Mitigation

Table 18 describes how the NTD programme in Eswatine will manage the risks through mitigating the threats or capitalizing on the opportunities that present to the expected results. It also provides alternative options to mitigations including changing strategy and project approach.

Table 18: Steps to mitigate risks	
Avoid	Change plans to circumvent the problem
Control	Reduce threat impact or likelihood (or both) through intermediate steps
Share	Outsource risk (or a portion of the risk) to a third party or parties that can manage the outcome.
Accept	Assume the chance of the negative impact
Monitor	Monitor and review process in which risk management is in place

Section 3.4. Performance and Accountability Framework

Table 19 describes strategic priorities, performance indicators, targets and time when such indicators are expected.

Table 19: Performance Accountablility framework			
Pillar 1: Accelerating programmatic action			
Strategic Priority	**Performance Indicators**	**Target**	**Date**
Establish an NTD programme for efficient coordination of NTD activities	NTD programme created	1	2024
	Terms of references for the NTD Programme secretariat developed	One set of TORs	2024
	Office space secured	1	2024
	Office equipment, materials, and vehicles procured	A set equipment	2024
	NTD disease specific expets assigned to the NTD programme	5	2024
: Integrated preventive chemotherapy to maintain 100% geographic coverage, scale down PC intervention where applicable and achieve the minimum disease specific treatment coverage level for SCH, LF and STH	No. of Tinkhundla with 100% MDA geographic coverage for SCH	59 Tinkhundla	Annually (2024-2028)
	Number of Tinkhundla with completed mapping of Lymphatic Filariasis	591	2024
	Proportion of MDA epidemiological coverage achieved for lymphatic filariasis in targeted Tinkhundla	100%	Annually (2024-2028)
	MDA epidemiological coverage for SCH achieved per Tinkhundla	100%	Annually (2024-2028)

	No of individuals treated for STH in targeted endemic tinkhundla	All individuals in endemic IUs	Biannually (2024-2028)
	Number of Tinkhundla where Social mobilization and BCC was implemented	59	Annually (2024-2028)
	% of HFs were CM NTD services was provided	100%	Annually 2024-2028
	% of HFs with no stockout of supplies for case management NTD supplies	100%	Annually (2024-2028)
	Number of Tinkhundla with completed mapping of Trachoma.	59	2025
	Number of individuals treated for trachoma	All individuals in trachoma endemic Tinhkundla	Annually (2024-2028)
	Number of Tinkhundla with completed mapping of taeniasis	59	2025
	No. of people trained on NTDs	500	Annually (2024-2028)
	CFR due to rabies reported	0	Annually (2024-2028)

Prioritize and strengthen monitoring and evaluation to track progress and decision making towards the 2030 goals	M&E framework developed	1	2024
	Tinkundhla M&E framework distributed	59 tinkhundla	2024
	Mid-term review of NTDs master plan conducted	1	2026
	End of term review of NTD master plan conducted	1	2028
	% of endemic tinkhundla with completed TAS for LF	100%	2028
	Tinkhundla completed Impact assessment surveys for SCH & STH	59	2024
	Number of sentinel sites Established.for SCH and STH surveillance monitoring	24	Annually (2024-2028)
	Tinkhundla conducted monitoring surveillance of SCH and STH	24	Annually 2024-2028
	No. of tinkhundla validated for elimination of trachoma as public health problem.	59	2028
	No. of tinkhundla completed burden assessment for at least one CM NTD	59	2028

Ensure timely, safe, and effective supply chain management of quality-assured NTD Medicines and other products up to the last mile	Number of Joint Application Form completed for PC-NTD medicines	1	Annually (2024-2028)
	PC-NTD incountry medicines distribution report produced	1	Annually (2024-2028)
	Data of CM NTDs provided by HF for early management of cases .	All health facilities	Monthly
	Number of Preventive Chemotherapy related SAE reported timely for pharmacovigilance investigation	All SAE	Annually during MDA (2024-2028)
Identify and prioritize operational research to facilitate NTD implementation	Number of reports on research for NTDs produced including research on KAP, uptake coverage, drug efficacy studies and pharmacovigilance testing	2	Annually (2024-2028)
	Number of research reports on assessment of the burden of female genital schistosomiasis produced	1	2025
	Number of Report on Pharmacovigilance investigations for PC-NTD MDAs produced.	1	Annually (2024-2028)
Performance Indicators for Pillar 2: Intensify cross-cutting approaches			
Strategic Priority	Performance Indicators	Target	**Date**

Strengthen identified platforms with similar delivery strategies and interventions ((MDAs, IVM, Morbidity management, Social mobilization for Behaviour Change and Communication, WASH etc.) for integrated approaches across NTDs	Integrated vector management (IVM) guideline developed	1	2024
	Number of health workers trained on Intergrated vector management	100	2025
	Number of times IVM chemicals supplied to tinkhudla	8	Annually 2024-2028
	No. of integrated community awareness activities conducted	36 (3 community activities per month)	Monthly
	No. of integrated trainings on NTD data management	1 training per year	Annually 2024-2028
	No. of rounds of integrated IVM interventions conducted	1	Annually 2024-2028

Strengthen national supply chain management systems to ensure timely, safe, and effective supply of quality assured NTD products and medicines	NTD donated medicines wavered for free importation into Eswatini	All NTD donated medicines	Annually 2024-2028
	Number of Medicine stores renovated for improved capacity and safe storage of NTD medicine	1	2025
	Number of health care workers trained on timely delivery of NTD medicine , stock monitoring and supply chain management and reverse logistics	75	2025
	Number of advocacy meeting for free importation meetings conducted	1	Annually 2024-2028
	NTD medicine logistics integrated in the National medicines logistic system	All NTD medicines	Annually 2024-2028
Integrated NTD planning, implementation, and monitoring	Annual programme review meetings conducted	1	Annually 2024-2028
	Number of multisectoral stakeholder meetings conducted	1	Annually 2024-2028
	CM NTDs whose medicines and supplies are procured	All CM NTD	Annually 2024-2028
	Number of supportive supervision conducted	1	Annually 2024-2028
	Number of international meetings attended	At least 1	Annually 2024-2028

Strengthen multi-sectoral coordination and response (WASH, One Health, Ministry of Education, Finance, Agriculture, Water and Land, etc.)	Number of multisectoral stakeholder meetings conducted planning meetings	1	Annually 2024-2028
	NTD technical working group established	1	2025
	Multisectoral strategic plan developed	1	2025
Integrate safety across NTD planning, implementation, and monitoring	No. annual NTD planning and review meeting conducted	1 workshop	Annually 2024-2028
	No. of annual plans submitted to ESPEN	1	Annually 2024-2028
	% Of NTDs managed according to Guidelines	100%	Annually 2024-2028

Performance Indicators for Pillar 3: Operating Models and culture to facilitate country ownership			
Strategic Priority	Performance Indicators	Target	**Date**
Strengthen country program ownership and leadership at all levels through organizational structures at national and local government with dedicated funding	Number of Advocy meetings for domestic funding conducted	1	Annually 2024-2028
	Number of community engament meetings conducted to improve community involvement in NTD activities	At least 1 meeting at all levels	Annually 2024-2028
	Advocacy meetings for Inclusion of NTDs in the National Health Sector Strategic Plan conducted	1	2024
	NTDs included in the National Health Sector Strategic Plan	All endemic NTDs	2025

	NTD included in the Primary Health Care (Universal Health Care)	All NTDs	2025
	Advocacy meetings for Inclusion of NTD indicators in national HMIS conducted	1	2024
	No. of partner coordination meetings with policy makers	1 workshop	Annually
	No. of coordination meetings conducted	4 workshops per year	Quarterly
	No. of NTDs Integrated into implementation guidelines (developed/reviewed)	1 workshop biennially to develop/review guidelines for 10 NTDs	2024, 2026, 2028
	No. of people trained on NTD involvement from other sectors (Education, WASH, etc)	200 people from the different sectors	Annually 2024-2025
Empower local government and authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions	No. of NTD training workshops conducted at national level	1	Annually 2024-2028
	No. of social mobilization sessions	10 activities	Annually 2024-2028
	No. of community leaders involved in MDA (at least one for each community)	200 leaders	Annually 2024-2028
	NTD Ambassadors identified	1	2024

Performance Indicators for Pillar4: Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs			
Strategic Priority	Performance Indicators	Target	**Date**
Build NTD programme capacity for resource mobilization	Potential donors mapped	10	2024
	NTD Programme Review meetings conducted	1	Annually 2024-2028
	Multi-sectoral stakeholders mapped	15	2024
	Multisectoral coordination meetings conducted	1	Annually 2024-2028
	Commemorate the World NTD Day	1	Annually
Strategic Priority 9: Promote community involvement and ownership of the program for optimal use of available resources	No. of people trained on resource mobilization	2	Annually
	No. of proposals submitted by the National programme for NTD implementation	2	Annually
	No. of NTD partner consultative meetings	4	Quarterly
	No. of partner support on NTD programme		Annually
	% of domestic funding allocation for NTDs		Annually
	No. of advocacy meetings with policy makers	1	Annually

Strategic Priority 10: Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.	No. of CHW participated on MDA campaign in every community	120 (2 CHW per Inkhundla)	Annually
	% Of at least one teacher participated on MDA campaign per school	100% (all schools should be represented)	Annually
	No. of community sensitization session (CHW) made for the community on NTDs	36 sessions	Annually

PART 4: BUDGETING for impact, Estimates and justifications.

Table 9: Five-year cost projections by Strategic Priorities

Activity	2024	2025	2026	2027	2028	TOTAL
Total	**48,295,000**	**78,211,899**	**39,748,788**	**55,236,802**	**44,177,192**	**265,669,681**
Strategic Pillar 1 - Accelerating programmatic action	**36,300,000**	**67,586,670**	**26,991,594**	**44,658,097**	**30,320,573**	**205,856,934**
Strategic Priority 1:1 - Integrated preventive chemotherapy to maintain 100% geographic coverage, scale down PC intervention where applicable and achieve the minimum disease specific treatment coverage level for SCH, LF and STH.	24,000,000	48,983,400	22,809,798	23,772,371	24,775,565	144,341,134
Strategic Priority 1:2 - Ensure early detection and prompt treatment of targeted case management NTDs	6,900,000	3,439,260	3,584,397	3,735,658	3,893,303	21,552,618
Strategic Priority 1:3 - Prioritize and strengthen monitoring and evaluation for tracking progress in line with the 2030 NTD Road map and SDGs	3,200,000	14,799,240	217,236	16,074,651	530,905	34,822,032
Strategic Priority 1:4 - Strategic priority Identify and prioritize operational research to facilitate NTD implementation	2,200,000	364,770	380,163	1,075,417	1,120,799	5,141,149
Strategic Pillar 2. Intensify cross-cutting approaches	**10,875,000**	**9,614,295**	**11,269,126**	**9,480,648**	**12,240,309**	**53,479,378**
Strategic Priority 2:1 - Strengthen and mainstream platforms with similar delivery strategies and interventions (MDAs, Morbidity management, social mobilization for Behaviour Change and Communication, WASH, IVM, EPI, MCH services, etc) for integrated approaches across NTDs	2,000,000	1,875,960	1,629,271	1,698,027	1,769,683	8,972,941
Strategic Priority 2:2 - Strengthen national supply chain management systems to ensure timely, safe, and effective supply of quality assured NTD products and medicines	7,000,000	5,211,000	7,603,266	5,660,088	8,258,522	33,732,876
Strategic Priority 2:3 - Integrated NTD planning, implementation, and monitoring	1,275,000	1,328,805	1,384,881	1,443,323	1,504,231	6,936,239
Strategic Priority 2:4 - Strengthen multi-sectoral coordination and response (WASH, One Health, Ministry of Education, Finance, Agriculture, Water and Land, etc.)	600,000	1,198,530	651,709	679,211	707,873	3,837,322
Strategic Pillar 3. Operating Models and culture to facilitate country ownership	**470,000**	**489,834**	**510,505**	**532,048**	**554,501**	**2,556,888**

Activity	2024	2025	2026	2027	2028	TOTAL
Strategic Priority 3:2 - Empower local capacity for social mobilization, communication and building support for NTD interventions	270,000	281,394	293,269	305,645	318,543	1,468,851
Strategic Priority 3:3 - Strengthen collaboration with other sectors (WASH, Environment, Education, Community organizations)	200,000	208,440	217,236	226,404	235,958	1,088,037
Strategic Pillar 4. Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs	**650,000**	**521,100**	**977,563**	**566,009**	**1,061,810**	**3,776,482**
Strategic Priority 4:1 - Build NTD programme capacity for resource mobilization	0	0	271,545	0	294,947	566,492
Strategic Priority 4:2 - Promote partnership and coordination for NTD programme implementation	200,000	208,440	217,236	226,404	235,958	1,088,037
Strategic Priority 4:3 - Advocate for domestic resource allocation	450,000	312,660	488,781	339,605	530,905	2,121,952

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Inflation rate 4.22% Category: Implementation costs Operational costs

Table 10: Five-year cost projections by Sub Activities

Sub-activity	2024	2025	2026	2027	2028	TOTAL
Total	**48,295,000**	**78,211,899**	**39,748,788**	**55,236,802**	**44,177,192**	**265,669,681**
Strategic Priority 1:1 - Integrated preventive chemotherapy to maintain 100% geographic coverage, scale down PC intervention where applicable and achieve the minimum disease specific treatment coverage level for SCH, LF and STH.						
Implement MDA for SCH/STH in all tinkhundla (#59)	14,000,000	14,590,800	15,206,532	15,848,247	16,517,043	76,162,623
Conduct mapping of LF and estimate population requiring interventions	0	4,168,800	0	0	0	4,168,800
Conduct MDA for LF in targeted Tinkhundla	0	3,126,600	0	0	0	3,126,600
Conduct Social mobilization and BCC	2,000,000	2,084,400	2,172,362	2,264,035	2,359,578	10,880,375
Conduct MDA for scabies where applicable	5,000,000	5,211,000	5,430,904	5,660,088	5,898,944	27,200,937
Conduct mapping for trachoma to determine the population requiring interventions	3,000,000	0	0	0	0	3,000,000
Conduct MDA for trachoma in endemic Tinkhundla	0	7,295,400	0	0	0	7,295,400
Conduct mapping to determine endemicity of taeniasis and to estimate population requiring intervention	0	12,506,400	0	0	0	12,506,400
Strategic Priority 1:2 - Ensure early detection and prompt treatment of targeted case management NTDs						
Strengthen Institutional capacity building for laboratory services'	1,400,000	0	0	0	0	1,400,000
Conduct burden assessment for Scabies and Rabies	1,500,000	0	0	0	0	1,500,000
Build capacity of HCWs on case management, morbidity management and disability prevention	1,400,000	1,459,080	1,520,653	1,584,825	1,651,704	7,616,262
Build capacity of HCWs, communities and teachers on NTDs	1,400,000	1,459,080	1,520,653	1,584,825	1,651,704	7,616,262
Build national capacity for timely detection and response for outbreak prone NTDs	500,000	521,100	543,090	566,009	589,894	2,720,094
Train on the use of JAP in estimating and joint requesting medicines Quantification and request for the procurement of supplies for PC NTDs (medicines, diagnostic kits)	200,000	0	0	0	0	200,000
Develop guidelines and manuals for NTDs	500,000	0	0	0	0	500,000
Conduct SCH impact assessment	0	14,590,800	0	15,848,247	0	30,439,047
Strategic Priority 1:3 - Prioritize and strengthen monitoring and evaluation for tracking progress in line with the 2030 NTD Road map and SDGs						
Establish and monitor sentinel sites surveillance for SCH and STH	200,000	208,440	217,236	226,404	235,958	1,088,037
Conduct baseline survey for CM NTDs	3,000,000	0	0	0	0	3,000,000
Prepare and submit dossier for the elimination of LF	0	0	0	0	294,947	294,947

Strategic Priority 1:4 - Strategic priority Identify and prioritize operational research to facilitate NTD implementation						
Strengthen national HMIS (Development of NTD Modules)	2,000,000	0	0	0	0	2,000,000
Carry out pharmacovigilance assessment/testing the safety of the medicines	200,000	208,440	217,236	226,404	235,958	1,088,037
Build institutional capacity to conduct research	0	156,330	162,927	169,803	176,968	666,028
Publish and disseminate research	0	0	0	679,211	707,873	1,387,084
Strategic Priority 2:1 - Strengthen and mainstream platforms with similar delivery strategies and interventions (MDAs, Morbidity management, social mobilization for Behaviour Change and Communication, WASH, IVM, EPI, MCH services, etc) for integrated approaches across NTDs						
Conduct integrated vector management for vector borne NTDs (SCH, LF) and other vector borne diseases such as malaria	1,500,000	1,563,300	1,629,271	1,698,027	1,769,683	8,160,281
Capacity building on provision of integrated services	300,000	312,660	0	0	0	612,660
Develop the NTD M&E Framework	200,000	0	0	0	0	200,000
Strategic Priority 2:2 - Strengthen national supply chain management systems to ensure timely, safe, and effective supply of quality assured NTD products and medicines						
Improve infrastructure	5,000,000	5,211,000	5,430,904	5,660,088	5,898,944	27,200,937
Build Capacity for timely delivery of supplies to IU level, monitor stock, improve reverse logistics	2,000,000	0	2,172,362	0	2,359,578	6,531,939
Strategic Priority 2:3 - Integrated NTD planning, implementation, and monitoring						
Conduct annual programme review and stakeholders' meetings	200,000	208,440	217,236	226,404	235,958	1,088,037
Conduct Quantification, application, and procurement of supplies for CM NTDS	5,000	5,211	5,431	5,660	5,899	27,201
Conduct supportive supervision	800,000	833,760	868,945	905,614	943,831	4,352,150
Participate in international meetings	270,000	281,394	293,269	305,645	318,543	1,468,851
Strategic Priority 2:4 - Strengthen multi-sectoral coordination and response (WASH, One Health, Ministry of Education, Finance, Agriculture, Water and Land, etc.)						
Strengthen coordination mechanism	350,000	364,770	380,163	396,206	412,926	1,904,066
Establish the NTD technical working group	0	52,110	0	0	0	52,110
Conduct Regular planning and review meetings	250,000	260,550	271,545	283,004	294,947	1,360,047
Develop multisectoral strategic plan	0	521,100	0	0	0	521,100
Build capacity for resource mobilization	270,000	281,394	293,269	305,645	318,543	1,468,851
Strategic Priority 3:3 - Strengthen collaboration with other sectors (WASH, Environment, Education, Community organizations)						
Involvement of community in NTD interventions	200,000	208,440	217,236	226,404	235,958	1,088,037

Strategic Priority 4:1 - Build NTD programme capacity for resource mobilization						
Conduct NTD Programme Review	0	0	271,545	0	294,947	566,492
Strategic Priority 4:2 - Promote partnership and coordination for NTD programme implementation						
Commemorate the World NTD Day	200,000	208,440	217,236	226,404	235,958	1,088,037
Strategic Priority 4:3 - Advocate for domestic resource allocation						
Development of IEC materials for NTDs	150,000	0	162,927	0	176,968	489,895
Conduct advocacy workshops for policy makers	200,000	208,440	217,236	226,404	235,958	1,088,037
Identify and renumerate NTD Ambassadors and champions (public figures for advocacy on NTDs)	100,000	104,220	108,618	113,202	117,979	544,019

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Inflation rate 4.22% Category: Implementation costs Operational costs

Activities - Sub-activities - Districts	Timeline for implementation												Estimated cost
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	SZL
Strategic Priority 1:1 - Integrated preventive chemotherapy to maintain 100% geographic coverage, scale down PC intervention where applicable and achieve the minimum disease specific treatment coverage level for SCH, LF and STH.													**24,000,000**
Implement MDA for SCH/STH in all tinkhundla (#59)													14,000,000
Conduct Social mobilization and BCC													2,000,000
Conduct MDA for scabies where applicable													5,000,000
Conduct mapping for trachoma to determine the population requiring interventions													3,000,000
Strategic Priority 1:2 - Ensure early detection and prompt treatment of targeted case management NTDs													**6,900,000**
Strengthen Institutional capacity building for laboratory services'													1,400,000
Conduct burden assessment for Scabies and Rabies													1,500,000
Build capacity of HCWs on case management, morbidity management and disability prevention													1,400,000
Build capacity of HCWs, communities and teachers on NTDs													1,400,000
Build national capacity for timely detection and response for outbreak prone NTDs													500,000
Ordering medicines and diagnostic kits for CM NTDs													0
Train on the use of JAP in estimating and joint requesting medicines Quantification and request for the procurement of supplies for PC NTDs (medicines, diagnostic kits)													200,000
Develop guidelines and manuals for NTDs													500,000
Strategic Priority 1:3 - Prioritize and strengthen monitoring and evaluation for tracking progress in line with the 2030 NTD Road map and SDGs													**3,200,000**
Establish and monitor sentinel sites surveillance for SCH and STH													200,000
Conduct baseline survey for CM NTDs													3,000,000
Strategic Priority 1:4 - Strategic priority Identify and prioritize operational research to facilitate NTD implementation													**2,200,000**

Activities - Sub-activities - Districts	Timeline for implementation												Estimated cost
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	SZL
Strengthen national HMIS (Development of NTD Modules)													2,000,000
Expert consultation and consensus on priority research areas for NTDs (KAP, sentinel sites, uptake coverage, impact assessment, drug efficacy studies)													0
Carry out pharmacovigilance assessment/testing the safety of the medicines													200,000
Strategic Priority 2:1 - Strengthen and mainstream platforms with similar delivery strategies and interventions (MDAs, Morbidity management, social mobilization for Behaviour Change and Communication, WASH, IVM, EPI, MCH services, etc) for integrated approaches across NTDs													**2,000,000**
Conduct integrated vector management for vector borne NTDs (SCH, LF) and other vector borne diseases such as malaria													1,500,000
Integrate with WASH/Environmental Health													0
Capacity building on provision of integrated services													300,000
Develop the NTD M&E Framework													200,000
Strategic Priority 2:2 - Strengthen national supply chain management systems to ensure timely, safe, and effective supply of quality assured NTD products and medicines													**7,000,000**
Advocacy for wavering free importation of donated medicines and supplies													0
Improve infrastructure													5,000,000
Build Capacity for timely delivery of supplies to IU level, monitor stock, improve reverse logistics													2,000,000
Strategic Priority 2:3 - Integrated NTD planning, implementation, and monitoring													**1,275,000**
Conduct annual programme review and stakeholders' meetings													200,000
Conduct Quantification, application, and procurement of supplies for CM NTDS													5,000
Conduct supportive supervision													800,000
Participate in international meetings													270,000

Activities - Sub-activities - Districts	Timeline for implementation												Estimated cost
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	SZL
Strategic Priority 2:4 - Strengthen multi-sectoral coordination and response (WASH, One Health, Ministry of Education, Finance, Agriculture, Water and Land, etc.)													**600,000**
Strengthen coordination mechanism													350,000
Conduct Regular planning and review meetings													250,000
Strategic Priority 3:1 - Strengthen country program ownership and leadership at all levels													**0**
Advocate for domestic funding													0
Improve community involvement													0
Advocate for Gender, equity, and human rights (GER) agenda													0
Advocate for Inclusion of NTDs in the National Health Sector Strategic Plan													0
Support NTD service provision at Primary Health Care (Universal Health Care)													0
Advocate for Inclusion of NTD indicators in national CMIS													0
Strategic Priority 3:2 - Empower local capacity for social mobilization, communication and building support for NTD interventions													**270,000**
Create community engagement and communication													0
Build capacity for resource mobilization													270,000
Promote Involvement of all community groups (swimmers, fishermen, farmers, business, etc)													0
Strategic Priority 3:3 - Strengthen collaboration with other sectors (WASH, Environment, Education, Community organizations)													**200,000**
Involvement of community in NTD interventions													200,000
Strategic Priority 4:1 - Build NTD programme capacity for resource mobilization													**0**
Conduct Mapping of potential donors													0
Strategic Priority 4:2 - Promote partnership and coordination for NTD programme implementation													**200,000**
Identify NTD stakeholders (internal, external)													0

Activities - Sub-activities - Districts	Timeline for implementation												Estimated cost
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	SZL
Commemorate the World NTD Day													200,000
Strategic Priority 4:3 - Advocate for domestic resource allocation													**450,000**
Development of IEC materials for NTDs													150,000
Conduct advocacy workshops for policy makers													200,000
Identify and renumerate NTD Ambassadors and champions (public figures for advocacy on NTDs)													100,000

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Annex 1 STH and SCH prevalence by Tinkhundla

Inkundla	Prevalence Rates		Method used	Year of survey & Reference
	STH %	SCH %		
Dvokodvweni	6.00%	8.70%	School-based Population Mapping Survey	2015
Ekukhanyeni	3.10%	11.20%	School-based Population Mapping Survey	2015
Endzingeni	5.00%	7.60%	School-based Population Mapping Survey	2015
Gege	0.40%	12.60%	School-based Population Mapping Survey	2015
Hhukwini	24.60%	6.90%	School-based Population Mapping Survey	2015
Hlane	5.60%	17.70%	School-based Population Mapping Survey	2015
Hosea	0.00%	19.20%	School-based Population Mapping Survey	2015
Kubuta	0.40%	20.60%	School-based Population Mapping Survey	2015
Kwaluseni	3.00%	10.20%	School-based Population Mapping Survey	2015
Lamgabhi	2.30%	14.00%	School-based Population Mapping Survey	2015
Lobamba	8.00%	6.50%	School-based Population Mapping Survey	2015
Lobamba Lomdzala	11.10%	16.40%	School-based Population Mapping Survey	2015
Lomahasha	6.10%	30.90%	School-based Population Mapping Survey	2015
Lubuli	5.70%	7.40%	School-based Population Mapping Survey	2015
Ludzeludze	1.50%	11.90%	School-based Population Mapping Survey	2015
Lugongolweni	10.00%	25.00%	School-based Population Mapping Survey	2015
Madlangempisi	6.00%	6.00%	School-based Population Mapping Survey	2015

Inkundla	Prevalence Rates		Method used	Year of survey & Reference
	STH %	SCH %		
Mafutseni	3.10%	12.90%	School-based Population Mapping Survey	2015
Mahlangatja	4.90%	4.90%	School-based Population Mapping Survey	2015
Mangcongco	0.00%	17.90%	School-based Population Mapping Survey	2015
Manzini North	2.00%	13.30%	School-based Population Mapping Survey	2015
Manzini South	0.40%	18.70%	School-based Population Mapping Survey	2015
Maphalaleni	18.10%	10.10%	School-based Population Mapping Survey	2015
Maseyisini	0.40%	22.00%	School-based Population Mapping Survey	2015
Matsanjeni	3.80%	18.50%	School-based Population Mapping Survey	2015
Mayiwane	9.80%	20.40%	School-based Population Mapping Survey	2015
Mbabane East	10.50%	8.80%	School-based Population Mapping Survey	2015
Mbabane West	6.00%	8.50%	School-based Population Mapping Survey	2015
Mhlambanyatsi	0.90%	8.90%	School-based Population Mapping Survey	2015
Mhlangatane	9.70%	17.70%	School-based Population Mapping Survey	2015
Mhlume	1.90%	18.30%	School-based Population Mapping Survey	2015
Mkhiweni	4.70%	9.60%	School-based Population Mapping Survey	2015
Motshane	23.00%	4.90%	School-based Population Mapping Survey	2015
Mpolonjeni	6.20%	14.10%	School-based Population Mapping Survey	2015
Mtfongwaneni	1.20%	7.30%	School-based Population Mapping Survey	2015

Inkundla	Prevalence Rates		Method used	Year of survey & Reference
	STH %	SCH %		
Mtsambama	0.40%	26.30%	School-based Population Mapping Survey	2015
Ngudzeni	0.40%	23.80%	School-based Population Mapping Survey	2015
Ngwempisi	0.40%	14.60%	School-based Population Mapping Survey	2015
Nhlambeni	0.00%	18.00%	School-based Population Mapping Survey	2015
Nkhaba	6.40%	3.00%	School-based Population Mapping Survey	2015
Nkilongo	8.00%	12.20%	School-based Population Mapping Survey	2015
Nkwene	1.50%	17.20%	School-based Population Mapping Survey	2015
Ntfonjeni	2.60%	4.60%	School-based Population Mapping Survey	2015
Ntondozi	4.20%	9.40%	School-based Population Mapping Survey	2015
Pigg's Peak	18.80%	9.50%	School-based Population Mapping Survey	2015
Sandleni	0.80%	24.90%	School-based Population Mapping Survey	2015
Shiselweni 1	0.40%	29.40%	School-based Population Mapping Survey	2015
Shiselweni 2	7.40%	17.50%	School-based Population Mapping Survey	2015
Sigwe	2.00%	19.90%	School-based Population Mapping Survey	2015
Siphofaneni	3.00%	11.70%	School-based Population Mapping Survey	2015
Sithobela	7.40%	31.40%	School-based Population Mapping Survey	2015
Somntongo	1.10%	10.60%	School-based Population Mapping Survey	2015
Tikhuba	6.00%	30.10%	School-based Population Mapping Survey	2015

Inkundla	Prevalence Rates		Method used	Year of survey & Reference
	STH %	SCH %		
Timphisini	15.10%	23.10%	School-based Population Mapping Survey	2015
Zombodze	1.90%	23.60%	School-based Population Mapping Survey	2015

Annex 2: NTD Endemicity Statuses and Five-year target populations by inkhundla

Inkhundla	LF	SCH	STH	Leprosy	Snakebite	Taeniasis	Foodborne	Scabies	2024	2025	2026	2027	2028
Total	**0**	**59**	**59**	**1**	**59**	**59**	**0**	**59**	**1,191,774**	**1,200,474**	**1,209,238**	**1,218,065**	**1,226,957**
Hhohho: Hhukwini	M	1	3	M	1	1	M	1	12,159	12,248	12,337	12,427	12,518
Hhohho: Lobamba	M	2	2	M	1	1	M	1	32,473	32,710	32,949	33,190	33,432
Hhohho: Madlangempisi	M	2	2	M	1	1	M	1	23,821	23,995	24,170	24,346	24,524
Hhohho: Maphalaleni	M	2	2	1	1	1	M	1	19,647	19,791	19,935	20,081	20,227
Hhohho: Mayiwane	M	2	2	M	1	1	M	1	17,248	17,374	17,501	17,629	17,757
Hhohho: Mbabane East	M	2	2	M	1	1	M	1	36,369	36,634	36,902	37,171	37,442
Hhohho: Mbabane West	M	2	2	M	1	1	M	1	26,371	26,563	26,757	26,953	27,149
Hhohho: Mhlangatane	M	2	2	M	1	1	M	1	25,684	25,872	26,061	26,251	26,442
Hhohho: Motshane	M	2	3	M	1	1	M	1	28,019	28,224	28,430	28,638	28,847
Hhohho: Ndzingeni	M	1	2	M	1	1	M	1	19,146	19,286	19,427	19,569	19,712
Hhohho: Nkhaba	M	1	2	M	1	1	M	1	20,661	20,812	20,964	21,117	21,271
Hhohho: Ntfonjeni	M	2	2	M	1	1	M	1	22,426	22,590	22,755	22,921	23,088
Hhohho: Pigg's Peak	M	2	2	M	1	1	M	1	19,888	20,033	20,179	20,327	20,475
Hhohho: Siphocosini	M	2	3	M	1	1	M	1	26,474	26,667	26,862	27,058	27,255
Hhohho: Timphisini	M	2	3	M	1	1	M	1	12,838	12,931	13,026	13,121	13,217
Lubombo: Dvokodvweni	M	2	2	M	1	1	M	1	31,558	31,789	32,021	32,255	32,490
Lubombo: Gigal	M	2	2	M	1	1	M	1	11,392	11,475	11,559	11,644	11,729
Lubombo: Lomahasha	M	2	2	M	1	1	M	1	22,379	22,543	22,707	22,873	23,040
Lubombo: Lubuli	M	2	2	M	1	1	M	1	14,333	14,438	14,543	14,649	14,756
Lubombo: Lugongolweni	M	2	2	M	1	1	M	1	27,670	27,872	28,075	28,280	28,487
Lubombo: Matsanjeni North	M	2	2	M	1	1	M	1	15,701	15,815	15,931	16,047	16,164
Lubombo: Mhlume	M	2	1	M	1	1	M	1	16,674	16,796	16,919	17,042	17,167

Inkhundla	LF	SCH	STH	Leprosy	Snakebite	Taeniasis	Foodborne	Scabies	2024	2025	2026	2027	2028
Lubombo: Mpolonjeni	M	2	2	M	1	1	M	1	14,224	14,328	14,433	14,538	14,644
Lubombo: Nkilongo	M	2	2	M	1	1	M	1	14,911	15,020	15,130	15,240	15,351
Lubombo: Siphofaneni	M	2	2	M	1	1	M	1	32,866	33,106	33,348	33,591	33,836
Lubombo: Sithobela	M	2	2	M	1	1	M	1	28,360	28,567	28,776	28,986	29,198
Manzini: Kukhanyeni	M	2	1	M	1	1	M	1	19,321	19,462	19,604	19,747	19,891
Manzini: Kwaluseni	M	1	2	M	1	1	M	1	60,660	61,103	61,549	61,999	62,451
Manzini: Lamgabhi	M	2	1	M	1	1	M	1	11,490	11,573	11,658	11,743	11,829
Manzini: Lobamba Lomdzala	M	2	2	M	1	1	M	1	22,056	22,217	22,379	22,542	22,707
Manzini: Ludzeludze	M	2	1	M	1	1	M	1	23,390	23,561	23,733	23,906	24,081
Manzini: Mafutseni	M	2	2	M	1	1	M	1	22,317	22,479	22,644	22,809	22,975
Manzini: Mahlangatsha	M	2	2	M	1	1	M	1	18,055	18,187	18,320	18,454	18,588
Manzini: Mangcongco	M	2	1	M	1	1	M	1	20,806	20,957	21,110	21,265	21,420
Manzini: Manzini North	M	2	1	M	1	1	M	1	34,726	34,979	35,235	35,492	35,751
Manzini: Manzini South	M	2	1	M	1	1	M	1	26,430	26,622	26,817	27,013	27,210
Manzini: Mhlambanyatsi	M	1	1	M	1	1	M	1	10,035	10,109	10,182	10,257	10,332
Manzini: Mkhiweni	M	2	2	M	1	1	M	1	23,987	24,162	24,339	24,517	24,696
Manzini: Mtfongwaneni	M	2	2	M	1	1	M	1	15,704	15,818	15,934	16,050	16,167
Manzini: Ngwemphisi	M	2	1	M	1	1	M	1	19,966	20,112	20,258	20,406	20,555
Manzini: Nhlambeni	M	2	1	M	1	1	M	1	12,778	12,871	12,965	13,060	13,155
Manzini: Ntondozi	M	2	2	M	1	1	M	1	14,957	15,067	15,176	15,287	15,399
Manzini: Nkomiyahlaba	M	2	1	M	1	1	M	1	14,030	14,132	14,236	14,339	14,444
Manzini: Phondo	M	2	1	M	1	1	M	1	23,534	23,706	23,879	24,053	24,229
Shiselweni: Gege	M	1	1	M	1	1	M	1	17,885	18,015	18,147	18,279	18,413
Shiselweni: Hosea	M	2	1	M	1	1	M	1	14,879	14,988	15,097	15,208	15,319
Shiselweni: Khubutha	M	2	1	M	1	1	M	1	5,910	5,953	5,997	6,040	6,084

Inkhundla	LF	SCH	STH	Leprosy	Snakebite	Taeniasis	Foodborne	Scabies	2024	2025	2026	2027	2028
Shiselweni: Maseyisini	M	2	1	M	1	1	M	1	29,898	30,117	30,336	30,558	30,781
Shiselweni: Matsanjeni South	M	2	2	M	1	1	M	1	10,623	10,700	10,779	10,857	10,936
Shiselweni: Methula	M	2	2	M	1	1	M	1	18,097	18,229	18,362	18,496	18,631
Shiselweni: Mbangweni/shiselweni 2	M	2	1	M	1	1	M	1	32,639	32,877	33,117	33,359	33,603
Shiselweni: Mtsambama	M	2	1	M	1	1	M	1	18,356	18,490	18,625	18,761	18,898
Shiselweni: Ngudzeni	M	3	1	M	1	1	M	1	8,956	9,021	9,087	9,153	9,220
Shiselweni: Nkwene	M	2	1	M	1	1	M	1	6,832	6,882	6,933	6,983	7,034
Shiselweni: Sandleni	M	2	1	M	1	1	M	1	18,053	18,185	18,318	18,452	18,586
Shiselweni: Shiselweni 1	M	2	1	M	1	1	M	1	9,361	9,430	9,498	9,568	9,638
Shiselweni: Sigwe	M	2	1	M	1	1	M	1	9,936	10,009	10,082	10,155	10,230
Shiselweni: Somntongo	M	2	2	M	1	1	M	1	8,440	8,501	8,563	8,626	8,689
Shiselweni: Zombodze Emuva	M	2	1	M	1	1	M	1	14,373	14,478	14,583	14,690	14,797

Annex 3: NTD Commodities Forecasting Dashboard

	2024	2025	2026	2027	2028	Total
DEC – Diethylcarbamizine	0	0	0	0	0	**0**
IVM – Ivermectin	0	0	0	0	0	**0**
ALB - Albendazole (with IVM or DEC)	0	0	0	0	0	**0**
ALB/MBD (alone or with PZQ)	1,191,774	1,200,474	1,209,238	1,218,065	1,226,957	**6,046,508**
PZQ - Praziquantel	3,165,070	3,188,175	3,211,449	3,234,892	3,258,507	**16,058,093**
TEO - Tetracycline eye ointment	0	0	0	0	0	**0**
ZMAX POS bottles	0	0	0	0	0	**0**
Zmax TABS - Zithromax tablets	0	0	0	0	0	**0**

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