7th ANNUAL MEETING OF NTD PROGRAMME MANAGERS IN AFRICA

Leveraging innovative tools & sustainable financing to advance NTD elimination in Africa

13-16 April 2026

Lilongwe, Malawi

African Union

World Health Organization
African Region

ESPEN
EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

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Attendance – Day 3

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Welcome, objectives of the day

8:30 - 8:45

SESSION 13

Trends in health/NTD financing, innovative financing and dedicated funding for NTD sustainability

8:45 - 10:30

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Trends in health/NTD financing, innovative financing and dedicated funding for NTD sustainability

Mesurable Progress

•According to the WHO Global Report on Neglected Tropical Diseases 2025, concerted efforts over the past two decades have contributed to a measurable decline in the global burden.
•In 2023, an estimated 1.495 billion people required interventions against NTDs, representing a 32% decrease from the 2010 baseline.
•By the end of 2024, 54 countries globally had managed to eliminate at least one NTD.
•The 2025 year-in-review by Uniting to Combat NTDs highlighted further progress, noting that 58 countries globally have now eliminated at least one NTD.
•This global achievement includes 24 countries across the African continent.

The Changing Financing Landscape

The financing environment for NTD programmes has become significantly more constrained:

•Rising global conflict, economic uncertainty, and reductions in development assistance for health are reshaping the operating context for endemic countries.

•The WHO Expanded Special Project for Elimination of NTDs (ESPEN) Strategy 2026–2030 warns of recent decreases in bilateral and multilateral aid.

•This reduction in aid includes the cessation of some USAID funding streams.

•These factors create severe risks for programme continuity, progress towards elimination targets, and the long-term sustainability of gains already made.

Shifting Focus to Country Leadership

•As Member States transition into the new ESPEN 2026–2030 strategic cycle, the focus is shifting decisively towards country leadership.
•A key priority is embedding sustainability into all aspects of NTD programme delivery.
•It is critical to equip endemic countries with the capacity to drive advocacy and resource mobilisation.
•This urgency is amplified by large funding shifts, including the reduction in US government development funding announced in early 2025.
•NTD priorities must be embedded within national planning and budgeting cycles, medium-term expenditure frameworks, primary health care and universal health coverage platforms, and decentralised financing systems.

Innovative and Domestic Financing Opportunities

- African NTD Program Managers have heavily requested specific guidance on private sector engagement at the national level.
- The 2025 Kikundi Advocacy Framework explicitly identifies private sector engagement as a significantly underutilized opportunity.
- Innovative financing refers to approaches such as structured private sector engagement, cross-programme integration, local philanthropic partnerships, and result-oriented financing.
- Successful advocacy efforts in 2025 at a major meeting in Abuja, Nigeria, demonstrated remarkable progress towards sustainable domestic financing.
- These efforts secured commitments to create dedicated budget lines for NTDs at the state level.
- National NTD programmes must generate necessary economic and health evidence to successfully advocate for increased funding from Ministries of Finance and Health.

The Path Forward

•Member States need a clear strategic understanding of what is changing in the NTD financing landscape.
•Countries must understand which domestic, sub-national, and innovative financing pathways are most relevant for building resilient, country-led responses.
•Member States must share actionable frameworks for national-level engagement to diversify funding sources.
•Programmes must strengthen commitment to the ESPEN 2026-2030 goal of fostering country leadership and sustainable, data-driven action.

Session Overview

•**Opening Remarks & Short Presentation (15 minutes):** This will provide an overview of the current NTD funding status.

•**Panel 1 Discussion (35 minutes):** This panel will focus on navigating the decline in global health financing and strengthening country leadership.

•**Panel 2 Discussion (35 minutes):** This panel will focus on domestic resource mobilization, integrating sub-national budgets, and engaging the private sector.

•**Reflections from the Floor (15 minutes):** The floor will be opened for Member States to share their own experiences and challenges.

THANK YOU

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ANNUAL MEETING OF
NTD PROGRAMME MANAGERS IN AFRICA

Health Break

10:30 - 11:00

SESSION 14
Country experiences on NTD financing
11:00 -12:00

The Evolving NTD Funding Landscape

- The funding landscape for NTDs in the African Region is experiencing a critical evolution.
- During the 2025 Annual Meeting in Lomé, stakeholders emphasized the fragility of relying on external funding and the urgent need for robust domestic resource mobilization.
- Recent USAID funding pauses in early 2025 interrupted essential mass drug administration (MDA) programmes, abruptly suspending interventions for an estimated 142 million people globally.
- This disruption has exposed critical vulnerabilities, forcing a strategic pivot toward national ownership and decentralized, country-led implementation.

Continental Progress and Leadership

•Despite significant financial hurdles, African nations continue to demonstrate remarkable leadership in achieving health milestones.
•As of 2025, 58 countries globally—including 24 across the African continent—have successfully eliminated at least one NTD.
•Notably, Togo has achieved historical progress by becoming the first country in the world to eliminate four distinct NTDs.

The Strategic Imperative: Integration and Efficiency

•As external development assistance shrinks, the success of national NTD programmes relies heavily on pivoting away from vertical operations and integrating services into established, broader health platforms.
•A 2025 programmatic review demonstrated that integrating MDA into maternal and child health (MCH) services in Rwanda yielded significant operational efficiency and achieved a 100% geographical coverage rate.
•Integration produces substantial cost savings; an economic analysis showed Madagascar's integration of MDA with routine polio campaigns reduced operational expenses by up to 89%.

Strategic Advocacy for Domestic Action

•Strategic, high-level advocacy is yielding quantifiable financial benefits and driving domestic resource mobilization.
•A 2025 convening in Abuja, Nigeria, showcased remarkable progress by securing joint commitments from state health commissioners to create dedicated NTD budget lines at the sub-national level.
•Equipping Member States with these peer-reviewed frameworks is essential to replicate advocacy successes and mitigate the impact of shrinking external finance.

Session Overview

- **11:00 – 11:05 | Opening Remarks:**
Framing the shift away from external funding dependence.

- **11:05 – 11:35 | Country Experiences (Plenary):**
- *Ghana:* Mainstreaming NTD financing into national health insurance.
- *Cameroon:* Multisectoral funding and integration into routine campaigns.
- *Egypt:* Funding post-elimination surveillance.
- *Zambia:* Advocacy models for sub-national resource mobilization.

- **11:35 – 11:55 | Reflections from the Floor:** Open dialogue for Member States to share experiences and challenges.

- **11:55 – 12:00 | Closing Synthesis:** Actionable takeaways for National NTD Master Plans.

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SESSION 15

Partner experience on innovative financing and domestic resource mobilisation

12:00 -13:00

Uniting to Combat NTDs

Mobilizing Domestic Resources for NTDs: Lessons from Nigeria and Tanzania

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The Funding Crisis: Why Action Is Urgent Now

Donor dependency exposed: The 2025 USAID funding pause abruptly suspended MDA programmes affecting an estimated 142 million people globally — exposing the fragility of externally-driven NTD financing.

Africa carries the burden: 40% of the global NTD burden falls on Africa. Yet most countries' health budgets remain well below the Abuja Declaration target of 15% of national budgets for health.

Enormous untapped returns: Every $1 invested in NTD control can leverage up to $26 in donated medicines. Nigeria alone stands to gain $19 billion in economic productivity by 2030 by meeting NTD elimination targets.

A continental imperative: The Addis Ababa Call to Action commits AU Member States to increase domestic financing and establish End Malaria-NTD Councils — the shift from dependency to ownership must now accelerate.

Source: Uniting to Combat NTDs; BMC Proceedings 2026; African Business 2025

High-Level Advocacy in Action: Nigeria's Story

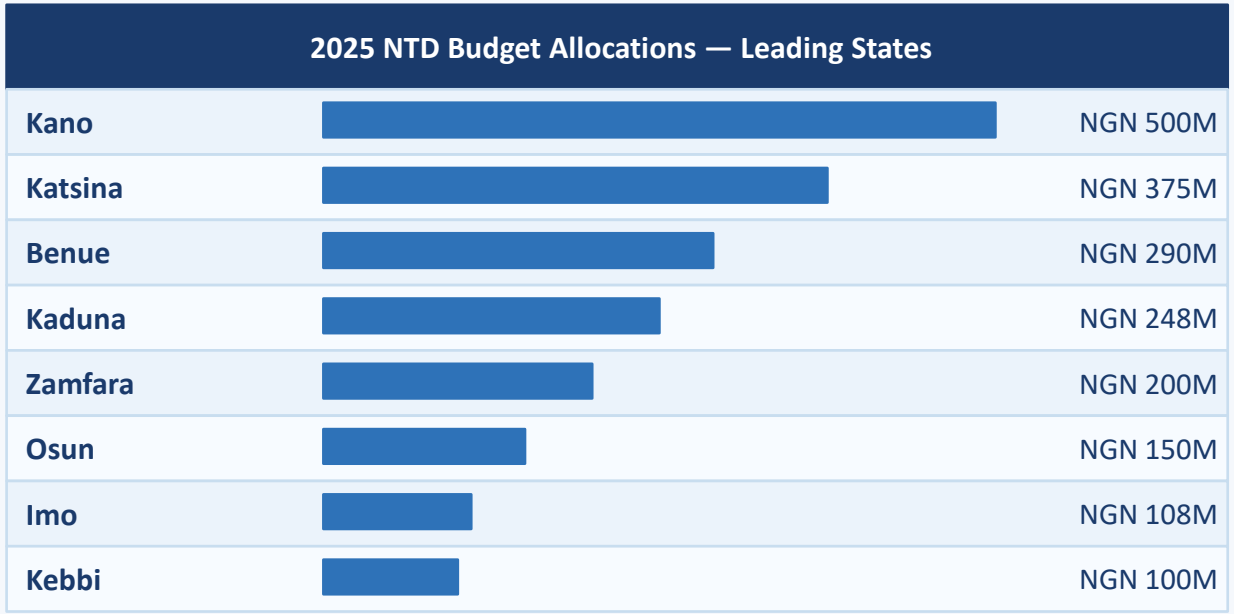
From Resolution to Reality

In November 2024, a high-level convening in Abuja — co-hosted by Nigeria's Federal Ministry of Health, Uniting to Combat NTDs, and The Global Fund — brought all 36 State Health Commissioners together.

A signed joint communiqué included a binding resolution: "Creating dedicated budget lines for NTDs at the State level."

Result: By 2025, 21 of 36 states had established dedicated NTD budget lines in their Medium-Term Expenditure Frameworks (MTEF) — a landmark in government-led health financing.

An Interstate NTD Advisory Committee was formed to sustain cross-sector collaboration and coordinate domestic financing.



+ 13 additional states with allocations from NGN 3M to NGN 80M

Key Lesson: One high-level convening of all state health commissioners — backed by a formal resolution — resulted in 21 states embedding dedicated NTD budget lines in their MTEFs within a single year.

Source: Uniting to Combat NTDs — Nigeria Makes Historic Strides (Nov 2025); Commissioners of Health Meeting (Nov 2024)

Nigeria: National Ownership of the Main NTDs

16

NTDs with dedicated national budget lines

All priority NTDs explicitly funded at the in national and subnation budgets

21/36

States with dedicated NTD budget lines (2025)

Within one year of the Abuja advocacy convening

NGN 2B+

Total sub-national NTD budget commitments

Across states that established new dedicated allocations

How Political Advocacy Delivered Results

01 Federal–State Convening

Federal Ministry of Health co-convened with Uniting to Combat NTDs bringing all 36 State Health Commissioners to Abuja in November 2024 for a high level advocacy meeting

02 Binding Joint Resolution

A formal communiqué committed every state to create dedicated NTD budget lines within their Medium Term Expenditure Frameworks.

03 Interstate Advisory Committee

A cross-state coordination body was established to track commitments, share lessons, and sustain cross-sector collaboration on NTD financing.

04 National Budget Lines

The Federal Government established dedicated lines for all 16 priority NTDs, with increased national allocations signalling full government ownership.

Source: Uniting to Combat NTDs — Cotonou Reflections; Nigeria Makes Historic Strides

Tanzania: A Blueprint for NTD Domestic Financing

Tanzania's NTD DRM Strategy 2024/25–2029/30 charts a systematic transition from donor dependency to government ownership, targeting 60% domestic funding of the NTD budget by 2026.

Strengthen Government Systems	Integrate into Health Financing	Diversify Funding Sources
Embed NTDs in Comprehensive Council Health Plans (CCHPs) — local governments plan and fund NTD activities independently	Advocate for NTD services within Universal Health Insurance (UHI Act 2023)	CSR contributions and social impact bonds (SIBs) for NTD case management
Integrate NTD budget lines into national planning and budgeting systems (PlanRep)	Include NTD patients as eligible beneficiaries under UHI earmarked taxes	Contract private sector providers for morbidity NTD case management services
Preferential NTD allocation to endemic councils with strong execution records	Embed NTDs in the Health Sector Strategic Plan (HSSP V 2021–2026)	Access World Bank IDA21 — Tanzania MoH is also working on a strategic IDA21 business case to secure dedicated funding for NTDs

RESULTS BY 2024

TSh 1.8B → 16.9B
NTD budget growth 2021–2024

0.61% → 23.35%
Domestic funding share growth

130 councils
Ran MDA without donor funds (2024)

Source: Tanzania DRM Strategy for NTDs 2024/25–2029/30; OHS Health — Case for Investing in NTDs

Integration: Maximising Efficiency Across Health Platforms

Integrating NTD services into routine health systems and existing campaigns reduces duplication, lowers costs, and builds programme resilience.

RWANDA — MCH Services	Integrating MDA into Maternal & Child Health services achieved 100% geographic coverage and reduced delivery costs by leveraging existing health worker networks.
MADAGASCAR — Polio Campaigns	Integrating MDA with routine polio campaigns cut operational expenses by up to 89% — one of the most significant documented NTD cost-savings from programme convergence.
BENIN — Local Budgets	Rapidly decentralised NTD financing through local government budgets and community delivery systems, sustaining MDAs despite USAID funding disruptions in 2025.
GHANA — Health Insurance (NHIA)	Piloted free lymphatic filariasis care under NHIA with Social Welfare Dept. Lymphedema is now recognised as a disability eligible for state social support payments.
KENYA — Social Health Authority	Embedded NTDs in the new SHA through income-based contributions and a costed NTD benefits package, delivered through Community Health Promoters nationwide.
ETHIOPIA — National Procurement	Reprioritised activities, redistributed medicines, and integrated NTD commodities into national procurement to partially bridge donor funding gaps domestically.

Source: BMC Proceedings 2026; Uniting to Combat NTDs — Cotonou 2025

Proven Strategies: A Menu for NTD Programme Managers

1 National & Sub-national Budget Lines

Nigeria model: high-level advocacy → state MTEFs. Tanzania: embed NTD budgets in CCHPs. The Addis Ababa Call to Action commits all AU members to this approach.

2 UHC / Health Insurance Integration

Include NTD services in national health benefit packages (Ghana NHIA, Kenya SHA). Services become routine and recurrently funded, not vertical donor-driven campaigns.

3 Integration with Health Campaigns

Attach MDA to immunisation, nutrition, WASH, and school health platforms. Madagascar cut operational costs by 89% integrating with routine polio campaigns.

4 Decentralised Local Government Financing

Embed NTD budgets in district/council plans with accountability systems. By 2024, 130 Tanzania councils ran MDA campaigns entirely without donor funding.

5 Private Sector & CSR Partnerships

Establish End NTD Funds and Malaria-NTD Councils to mobilise CSR. Social impact bonds (SIBs) can finance specific NTD case management services.

6 Multilateral & Innovative Finance

Include NTDs in World Bank IDA21 proposals. Explore debt-for-health swaps, AfDB instruments, and GFATM co-financing to bridge remaining investment gaps.

Source: PMC/Tropical Medicine and Health 2025; Speak Up Africa 2025; Addis Ababa Call to Action; African Business 2025

Keys to Success: A Political Advocacy Framework

Evidence from across the continent identifies four mutually reinforcing enablers of successful domestic resource mobilisation:

01 High-Level Political Backing

- Presidential & Cabinet champions (Guinea Worm model)
- Ministerial co-convening of health-finance dialogues (Nigeria)
- Parliamentary champions raising NTDs in budget debates (Senegal)
- Public declarations and media campaigns to build political will

02 Evidence-Informed Advocacy

- Every $1 invested leverages up to $26 in donated medicines
- Business case presented to Ministries of Finance, not just Health
- Costed NTD master plans and funding-gap analyses as tools
- ROI studies: Nigeria gains $19B in productivity by 2030

03 Multisectoral Process

- Multi-actor committees spanning Finance, Planning and Health
- Private sector, civil society, and partners engaged jointly
- Interstate NTD advisory committees for sustained engagement
- Commitments anchored in national resolutions and MTEFs

04 Accountability & Tracking

- Sign Kigali Declaration; use public Commitment Tracker
- Integrate NTD indicators into national HMIS (Tanzania)
- Monitor budget execution — not just nominal allocations
- Use Annual NTD PMM for peer accountability and learning

Source: BMC Proceedings 2026; PMC/Tropical Medicine and Health 2025; Addis Ababa Call to Action

Call to Action for NTD Programme Managers

Translating this session's lessons into national action:

NTD Programme Managers

- Develop a costed NTD business case for your Ministry of Finance, aligned with national health priorities
- Advocate for NTD budget lines in national & sub-national MTEFs — convene health commissioners and governors' offices
- Embed NTDs in existing campaigns (immunisation, WASH, nutrition) to deliver services at minimal extra cost
- Sign the Kigali Declaration and enter commitments in the Commitment Tracker for AU accountability

AU Commission & WHO ESPEN

- Facilitate peer-learning exchanges between countries with secured budget lines and those still working toward them
- Provide technical assistance to Ministries of Finance on quantifying and communicating NTD investment returns
- Establish regional monitoring of domestic NTD financing commitments under the Abuja Declaration
- Scale End Malaria-NTD Councils as cross-sectoral financing platforms nationally and sub-nationally

"It is imperative that Ministries of Health and Finance collaborate to implement robust domestic funding strategies — reflecting true national ownership and political commitment." — AU Commission

Source: Uniting to Combat NTDs — Cotonou Reflections; Addis Ababa Call to Action (AU Member States)

THANK YOU

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Annual Meeting of NTD Programme Managers in Africa

Convened by WHO ESPEN and the African Union Commission

The END Fund

THE END FUND

END Fund's Experiences on Innovative Financing and Domestic Resource Mobilization.

April 15, 2026

From Advocacy to Implementation: Key Phases

1. Political Engagement & Concept Development	2–3 months
2. Technical Coordination & Proposal Design	3 months
3. Approval & Legal Formalization (MOU Signing)	4 months
4. First Tranche Disbursement & Due Diligence	1 month
5. Implementation Planning & Plan Revision	4 months
6. Training & Microplanning	2 months
7. Plan Review & Refinement Workshop	1 month
8. Verification & Reporting (Public Finance Management (PFM) Regulations)	1 month

Example 1: Oromia Region (Co-financing)

Oromia Co-financing Project | Workflow

Executive phase flow showing the documented sequence, date range, approximate time, and key output for each step.

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
						
Political engagement and concept development	Technical coordination and proposal design	Approval and legal formalization	First tranche and due diligence	Plan development & revision	Training & micro-planning	Plan review and refinement workshop
50:50 concept documented	Budget template shared	MoU / agreement signed	75% tranche + DD	12-month plan developed	Managers trained in Adama	Review workshop in Bishoftu
Sep 2023 - 16 Nov 2023	*8 Nov 2023 - 23 Feb 2024*	*7 Nov 2023 - 1 Mar 2024*	*1 Mar 2024 - 29 Mar 2024*	*Late Mar 2024 - 15 Jul 2024*	*16 Jul 2024 - 20 Aug 2024*	*10 Dec 2024 - 14 Dec 2024*
2.5 months	**3.5 months**	**3.8 months**	**4 weeks**	**3.5 months**	**5 weeks**	**5 days**

Leverage Ratios- Oromia Region

TEF leverage ratio with governments is 1:1 funding. Below are achievements from the Oromia Region (Ethiopia):

Districts Treated	People Reached	Trainings	TT Surgeries Performed	Zones Trained
TARGET	TARGET	TARGET	TARGET	TARGET
77	2,592,503	25	1,500	16
ACHIEVED	ACHIEVED	ACHIEVED	ACHIEVED	ACHIEVED
233	7,842,047	20	1,204	16

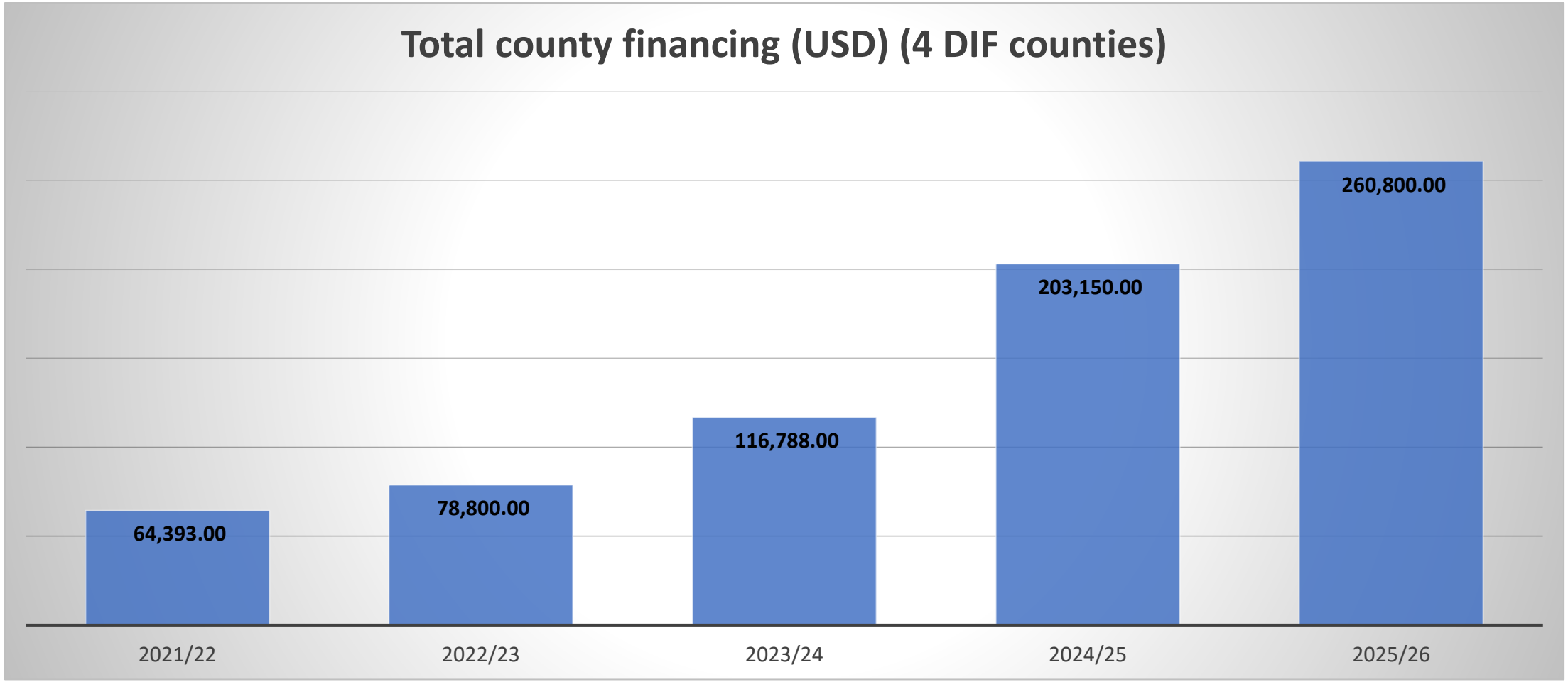
Note: Achieved figures show governments exceeded expectations on districts and population reach for SCH treatment.

Example 2: Kenya

Deworming Innovation Fund (DIF): STH/SCH interventions, in four Kenyan counties.

National and County governments have taken more responsibility for planning, financing and delivery of interventions

ARISE supported counties -Siaya and Kilifi contributing 88,000 USD for procurement of drugs)



Replication Conditions

The following conditions must be in place for successful mobilization, design and implementation of co-financing:

1. Political commitment translating into action
2. Buy-in and leadership from the most senior health official
3. Buy-in and leadership of the MOH technical teams
4. Long-standing partnerships between donors and governments to create trust
5. Multi-year budget commitments
6. Mutual agreements and co-creation of a pipeline of high-priority interventions
7. An enabling legal/regulatory framework for co-financing
8. Measurements tool for M&E
9. Ongoing cultivation for relationship building

From Donor Dependence to Domestic Ownership

CHALLENGE	SOLUTION	NEE
Donor-reliance/ shrinking external funding on Public Health/ drug donations	Integrated government-funded STH/ SCH program (carefully managed transition process) Policies to support integrated STH/SCH interventions	Readiness assessment & Strengthening existing infrastructure, especially at the PHC-level, for sustainable NTD elimination (decremental investment) Policy formulation/ strengthening of existing policies
	Domestic financing initiatives	Granular epi & vector data. Incentivize investment from the public and private sectors
	Multi-sectoral approach to elimination	Investment case with clear ROI to target Education, Environment & Finance sectors, highlighting the value of each sector on elimination (Feasibility Assessments)
	Low-cost, high-impact interventions (prioritization)	Costed interventions with clear ROI

Key Takeaways

- 18–24 months required from resource mobilization to implementation
- 1:1 leverage ratio — governments match donor funding
- Results in Oromia significantly exceeded targets for SCH treatment
- Success requires political commitment, senior leadership buy-in, and enabling legal frameworks
- Long-standing trust between donors and governments is foundational

THANK YOU

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NTD PROGRAMME MANAGERS IN AFRICA

DAWH

EXPERIENCES ON INNOVATIVE FINANCING AND DOMESTIC RESOURCE MOBILIZATION

Dr. Anil Fastenau

Global Health Advisor

Head of Program Unit

GLRA German Leprosy & TB Relief Association

WHY SUSTAINABLE FINANCING MATTERS

- NTDs disproportionately affect the most marginalized and vulnerable populations.
- External donor dependence threatens programme sustainability.
- Domestic resource mobilization is critical for long-term impact.
- Financing NTDs is an investment in health, equity, and development.

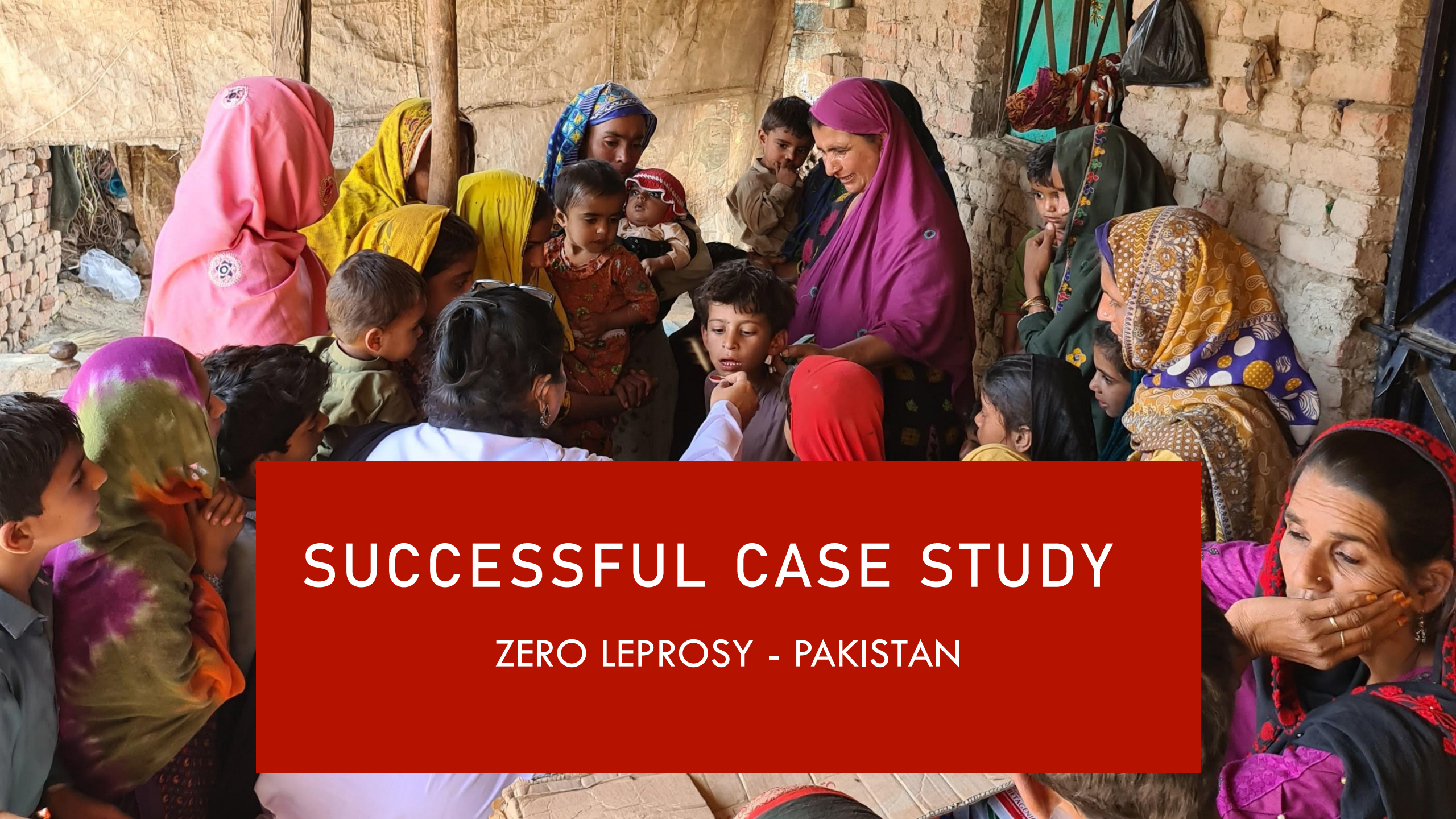
GLRA'S APPROACH TO RESOURCE MOBILIZATION

Our Strategic Pillars:

- Advocacy and policy engagement
- Public–private partnerships
- Country ownership and domestic financing
- Research and innovation
- Networking and multisectoral collaboration

INNOVATIVE FINANCING APPROACHES BY GLRA

- **Blended Financing:** Leveraging donor funds to catalyze domestic investments.
- **Public–Private Partnerships:** Collaboration with governments, NGOs, and academia.
- **Integration into National Health Systems:** Aligning NTD programs with UHC.
- **Co-Financing Models:** Shared funding between governments and partners.
- **Catalytic Funding:** Seed investments that stimulate domestic commitment.

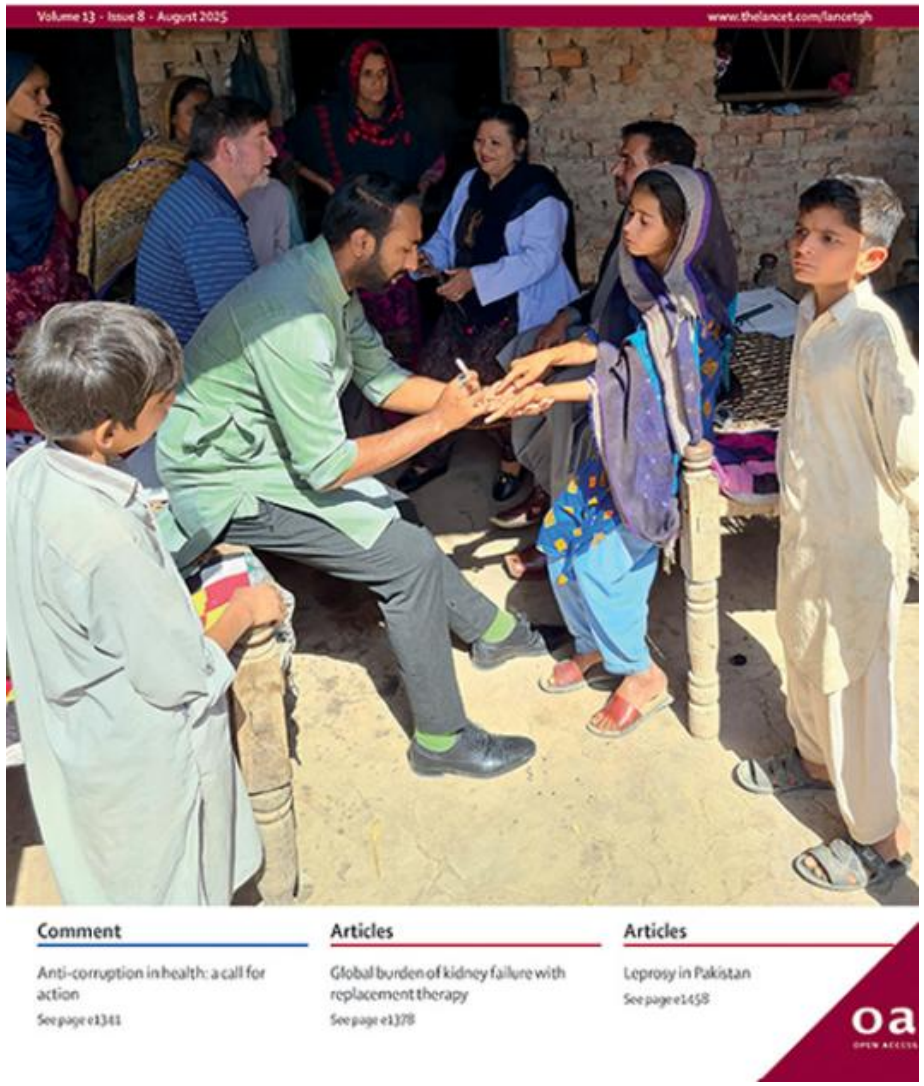


SUCCESSFUL CASE STUDY

ZERO LEPROSY - PAKISTAN

POWER OF LANGUAGE

- **Policy Support:** Strategic language shapes perceptions and builds political commitment.
- **Persuasion:** Tailored messages, economic benefits, and moral responsibility influence policymakers and stakeholders.
- **Inspiration:** Compelling success stories and the vision of a leprosy-free world drive action and resource mobilization.



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Pakistan on the Road to Zero Leprosy, an analysis of routine data for the period 1980–2022: a retrospective cohort study

Muhammed Iqbal [a] · Anil Fastenau, MD [a,c] · Abdul Salam [a] · Iram Iqbal Sadia, MD [b] · Isabel Fernandes, MBBS [a] · Ali Murtaza, MBBS [a] · et al. Show more

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Zero leprosy is within reach: eliminating leprosy in low-endemic settings demands political will

Anil Fastenau [a,b,c]

ADVOCACY & LOBBY

- **Raise Awareness:** Inform public and policymakers
- **Influence Policy:** Support funding and research
- **Engage Policymakers:** Secure commitments and funding
- **Build Alliances:** Partner with NGOs and international bodies

COUNTRY OWNERSHIP

- **Leadership:** Drive zero leprosy / NTD elimination initiatives
- **Resource Allocation:** Reflect commitments in budgets
- **Community Engagement:** Involve local authorities to ensure political commitment
- **Decentralized Implementation:** Tailor interventions locally

NETWORKING

- **Multidisciplinary Approach:** Engage various experts
- **Best Practices:** Share knowledge and strategies
- **Global and Local Networks:** Create collaboration platforms
- **Continuous Learning:** Establish training mechanisms

FOCUSING ON SUCCESS STORIES

- **Case Studies:** Share successful leprosy / NTD elimination examples
- **Role Models:** Feature individuals and communities
- **Positive Outcomes:** Demonstrate benefits of NTD elimination efforts
- **Replication:** Encourage adoption of successful strategies

RESEARCH

- **Evidence-Based Practices:** Use latest scientific evidence
- **Innovative Solutions:** Develop new tools and strategies
- **Real-World Application:** Translate findings into practical interventions
- **Continuous Improvement:** Refine and improve strategies

THANK YOU VERY MUCH!

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Parallel Session A – 16.1
Diagnostics for Schistosomiasis and other NTDs
14:00 - 15:30

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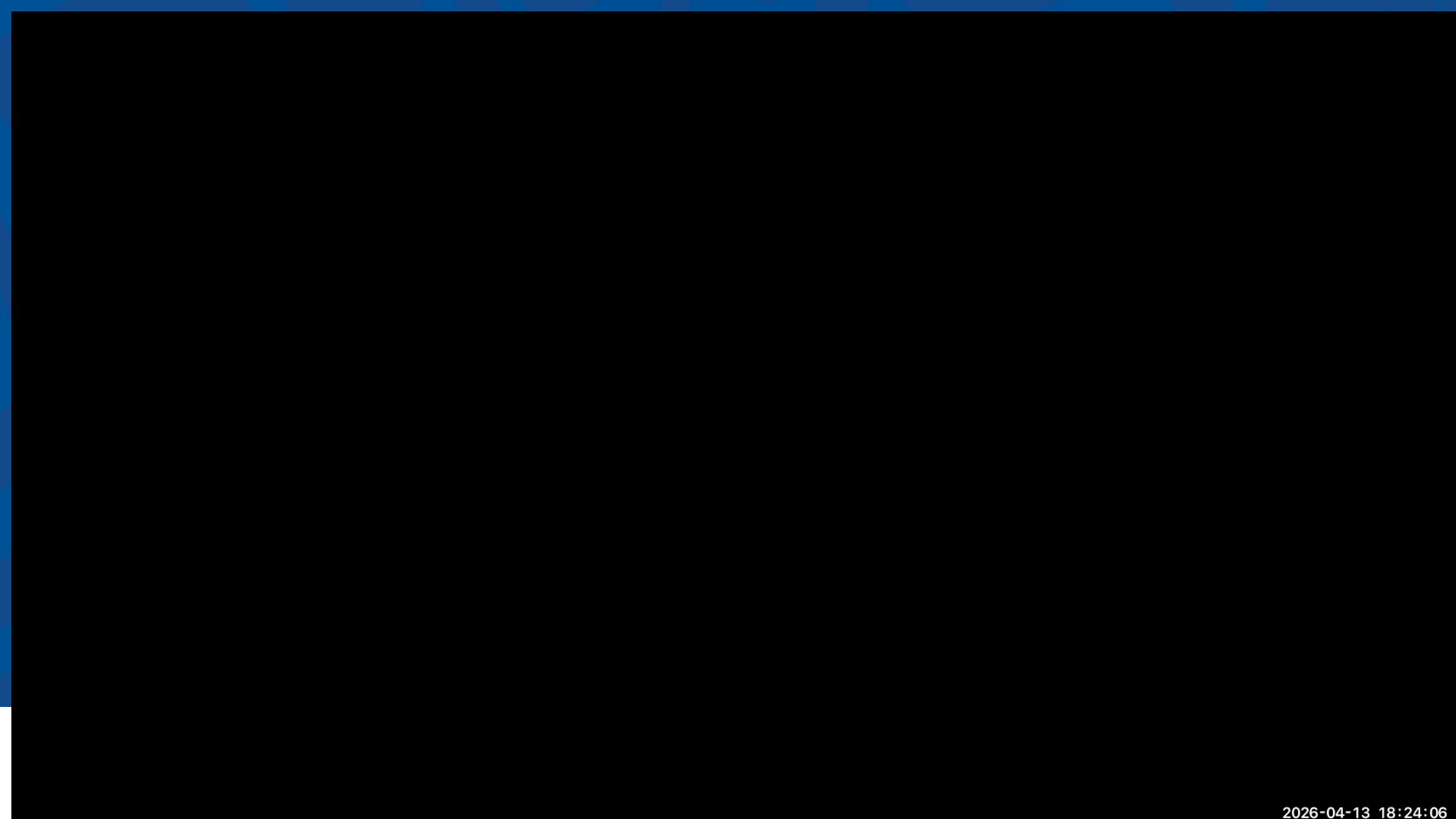
Agenda

Duration	Session Component	Presenter
5 min	Opening and objectives and data gaps	Pauline Mwinzi WHO-AFRO/ESPEN
15 Min	VL RDT requirement in eastern Africa - a compelling case of urgency	Recorded video Saurabh Jain, WHO-HQ
20 min	New version of POC-CCA for SCH diagnostics	Erik Coumou, Landcent
10 min	Country perspectives	Rwanda, experience on CCA
15 min	CAA: Readiness of a novel antigen-based RDT for integration into national SCH M&E frameworks	Sarah Hingel, FIND
5 min	Country perspectives	Kenya experience on CAA Wyckliff Omondi and Sammy Njenga
10 min	Q&A	
2 min	Closing takeaways, actions and closing	ESPEN

16.1B. VL RDT requirement in eastern Africa – a compelling case of urgency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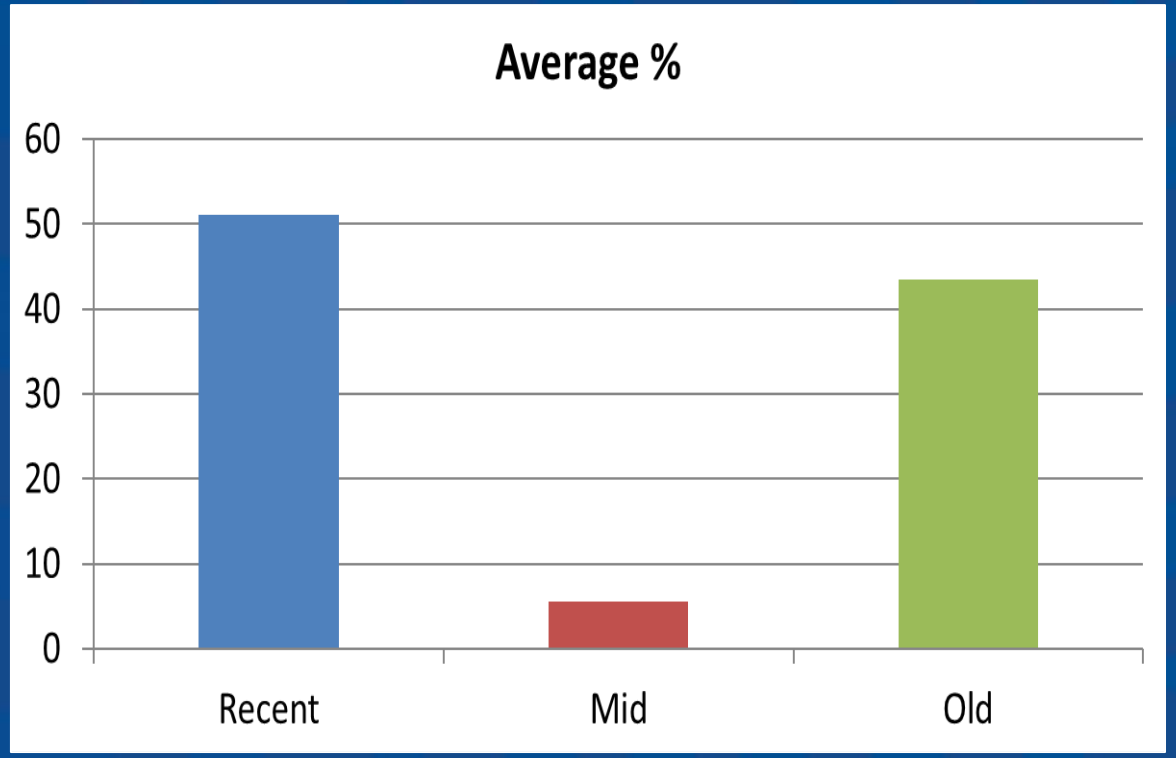
Schistosomiasis progress towards EPHP is increasingly data-intensive

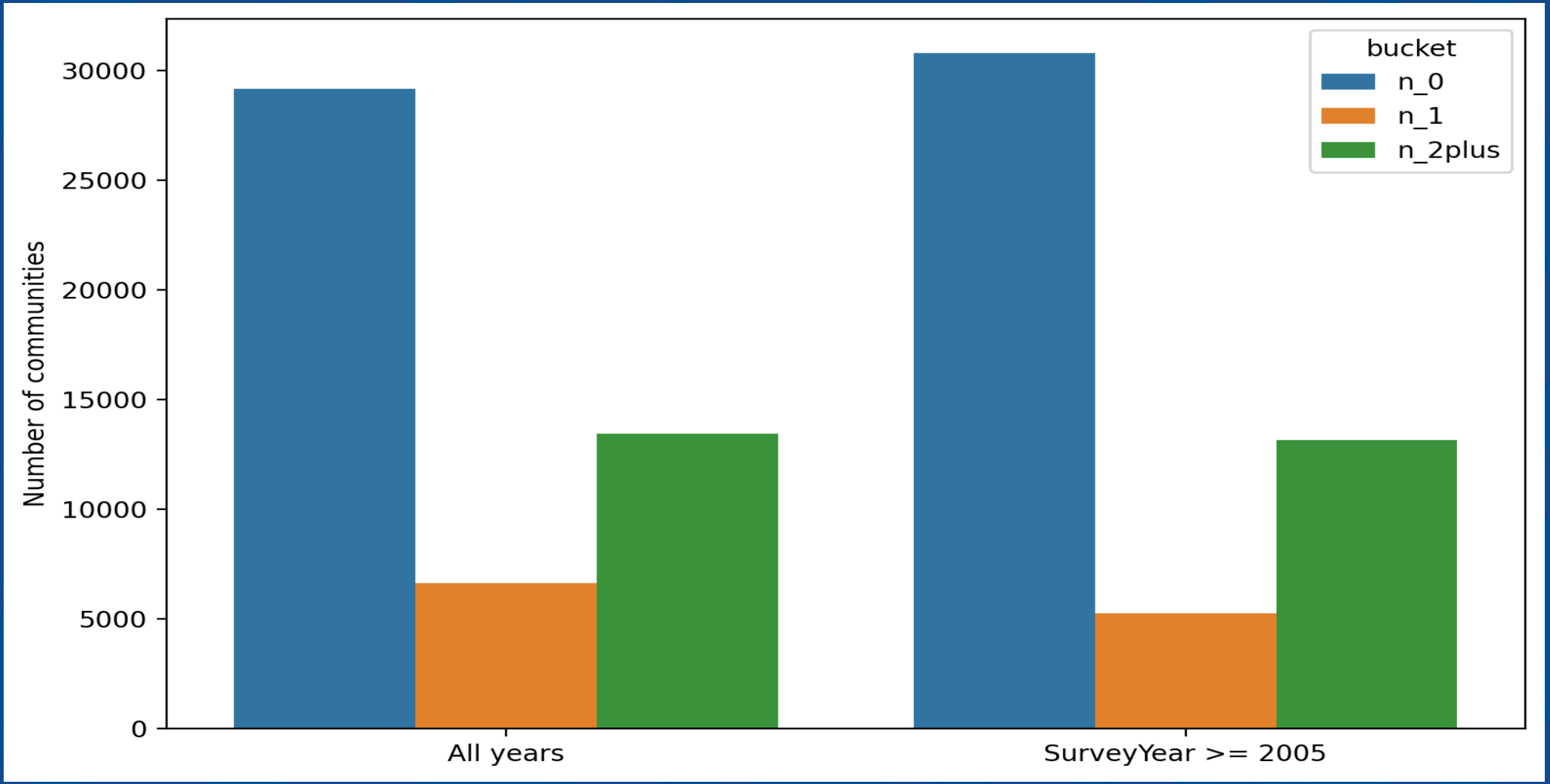
- Many countries in the Africa Region are transitioning from morbidity control to elimination and post-MDA surveillance
- Programme decisions now require high-resolution, recent, and reliable epidemiological data
- However, significant data gaps persist across implementation units (IUs)
- ~43% of IUs rely on outdated epidemiological data (>10 years)
- Only ~51% of IUs have recent data (<5 years)



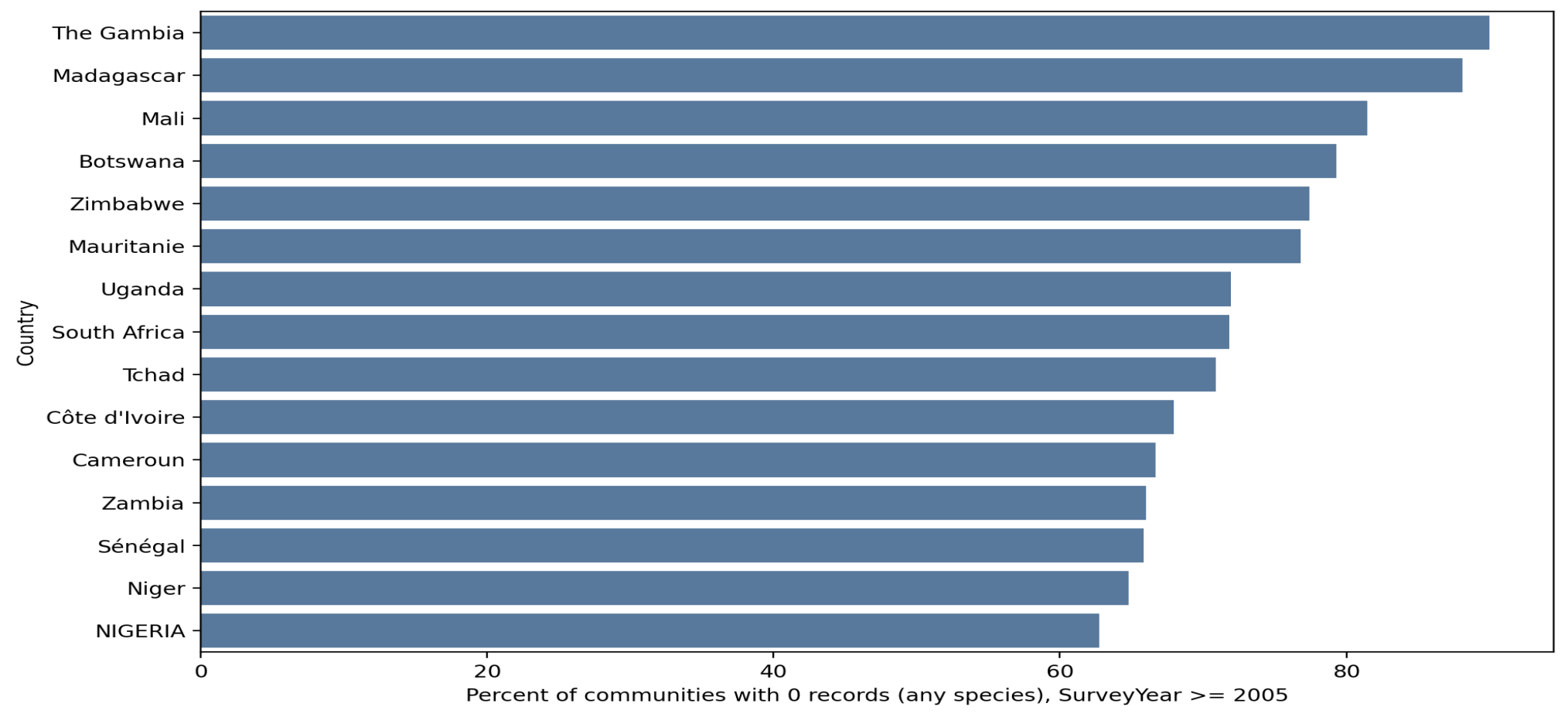
Community level data gaps

Endemicity Category	N sub-IUs	% of total (58,840)	% of known (25,940)
High	2,731	4.5%	10.5%
Moderate	7,492	12.4%	28.9%
Low	6,308	10.4%	24.3%
Not endemic	9,408	15.5%	36.3%
Unknown	34,705	57.2%	—
Total	60,644	100%	—

Comparison All years vs >2005



Top 15 countries with highest proportion of 0 site surveyed



Emerging Opportunities: Next-Generation Diagnostics

- Advances in point-of-care diagnostics are transforming SCH surveillance
- Improved POC-CCA availability and manufacturing reliability
- Development of novel antigen-based rapid diagnostic tests (RDTs)
- Example: CAA-based RDT detecting multiple Schistosoma species
- Field evaluations (Kenya, Philippines) show strong potential for programmatic use

Objectives of This Session
General objectives

i) To better understand how readily available quality-assured, point of care schistosomiasis diagnostics can strengthen the use of quality data and supporting information on the intensity of infection that supports countries with program decision-making towards elimination, in alignment with WHO normative guidance.

ii) To assess the readiness of a novel antigen-based RDT for integration into national SCH M&E frameworks, drawing on field evidence and country programme experience.

- To highlight evolving diagnostic needs across SCH control, elimination, and surveillance
- To present prevailing epidemiological data gaps
- To review WHO-aligned use of POC-CCA diagnostics
- To present updates on manufacturing and availability of SCH diagnostics
- To share country experiences with POC-CCA implementation
- To introduce novel CAA-based RDT and its field evaluation results
- To identify practical actions for integrating diagnostics into national programmes

THANK YOU

13-16 April 2026

Lilongwe, Malawi

African Union

World Health Organization
African Region

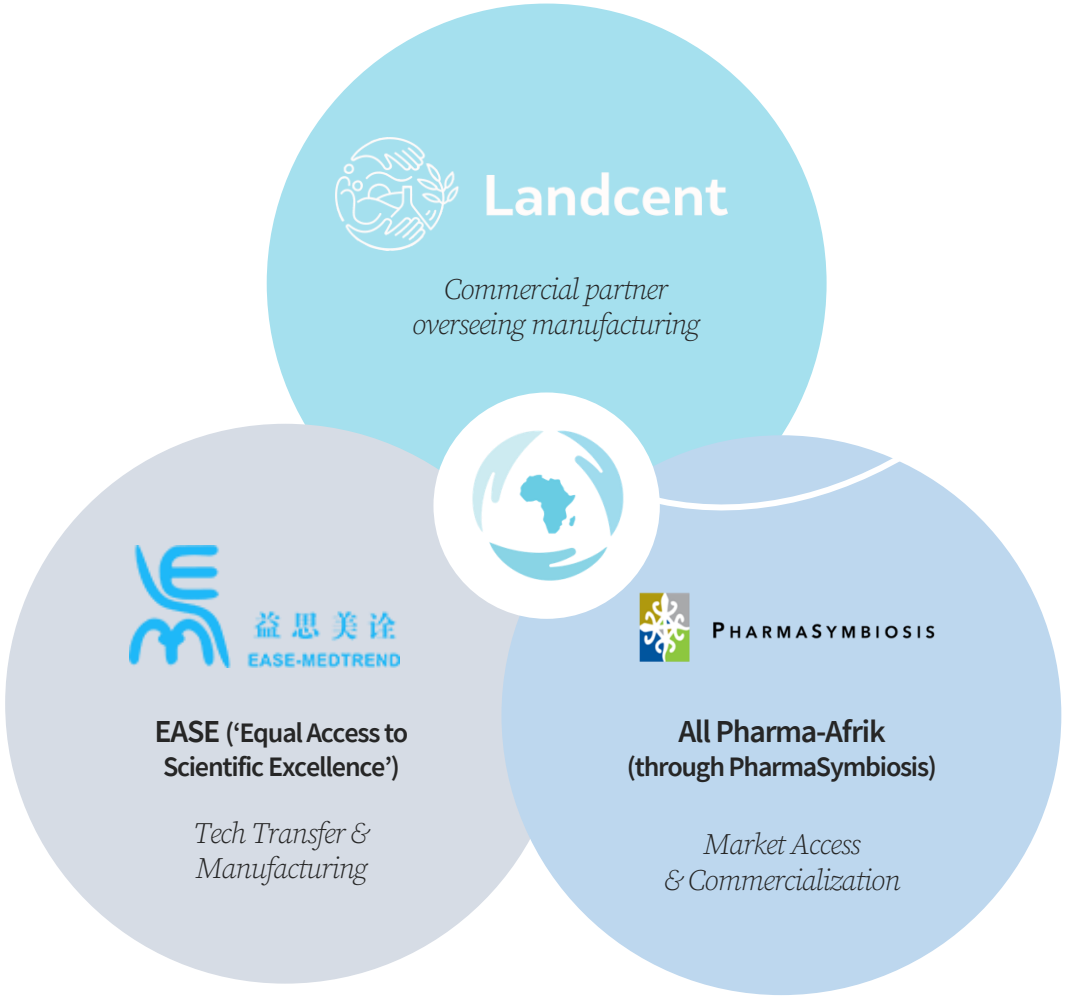
EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

ANNUAL MEETING OF
NTD PROGRAMME MANAGERS IN AFRICA

16.1A. Strengthening countries with novel, WHO-aligned SCH diagnostics to address data gaps

Leveraging the innovative diagnostics POC-CCA test to advance schistosomiasis control and monitoring

Partner organizations behind POC-CCA3



EDA
EASE - Dx Africa

Product Development and R&D Partners:

Leids Universitair Medisch Centrum — *Antibody Developer – Advisor*

Mondial Diagnostics — *Test developer – Quality Control*

Accurate diagnostics are essential to measure impact and guide program decisions

What is POC-CCA3?

A rapid lateral flow assay made to detect schistosomiasis

- Detects *S. mansoni* infections in urine
- WHO recommends POC-CCA as alternative to Kato-Katz for *S. mansoni* endemic areas since 2017
- Available now to order for research use

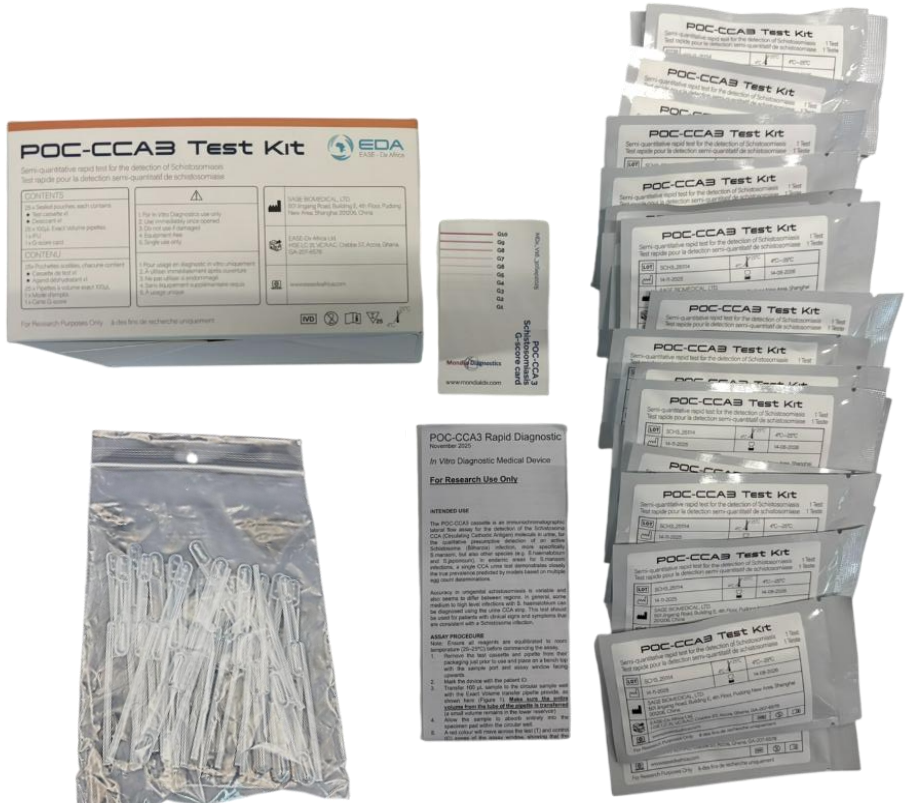
What's new in POC-CCA3?

- Rigorous manufacturing quality and QC
- Use of recombinant antibodies
- Standard inclusion of G-score reference card
- Minimal batch-to-batch variability
- Highly sensitive for *S. mansoni*
- Smartphone app for test readout under development with partner

Product Details

- **Expiration dates:** 1 year (continued stability study to confirm extension)
- **Storage:** Store between 4 - 25 C
- **Packaging Includes**
  - 25 tests in aluminum pouch with desiccant
  - 25 exact volume pipettes (100µL)
  - Instructions For Use
  - G-score card
- **Procurers of the product:** National control programs, research institutes, NGO's, other
- **Manufacturing**
- SAGE Biomedical (EASE Medtrend) in Shanghai
- Quality oversight

  QC SAGE Biomedical and Quality release MondialDx



A comparison of diagnostic performance and programmatic usability

POC-CCA3 vs Kato-Katz

Scan the code to learn more

Key Features Compared

Feature	POC-CCA3	Kato-Katz
Detects	Circulating *schistosome* antigens in urine	Schistosome eggs in stool
Sensitivity	High, especially in low-intensity infections	Lower in low-intensity infections
Speed	20 minutes	Hours, requires microscope and trained operator
Throughput	400-500 test per day per operator (50 per 30 min)	+/- 50 slides per day per operator
Advantages	Semi quantitative G-score, quick and easily scalable, minimal training	Quantitative analysis, species differentiation
Limitations	Can't check for other worm infections (STH) at the same time, unlike microscopy.	Time-consuming, discomfort from patients, lower sensitivity in low infection areas

Accurate diagnostics are essential to measure impact and guide program decisions

Recommended use Cases for POC-CCA3

Prevalence Monitoring

POC-CCA3 recommended as alternative or complementary approach to Kato-Katz.

Impact Assessments

POC-CCA3 enables monitoring of progress towards elimination as a public health problem by providing insight in prevalence and intensity.

Test and Treat Programs

In low prevalence settings POC-CCA3 could facilitate transition to Test & Treat, and assist country programs in the road towards elimination.

Sub-District Surveying

POC-CCA3 supports precision mapping, by helping country programs identify hotspots and guide targeted interventions.

POC-CCA3 experience across Africa since 2024

Field experience and current research

- **Uganda** COR NTD-study -2024, of 2610 test of 3 batches compared to old POC-CCA
- **Cote d'Ivoire** – HOTSPOT -17000 Test in 2025-2026
- **Malawi** Impact assessment 3500 pt study in 2025
- **Tanzania:** Test and treat pilots 2025
- **Ethiopia:** STOP MDA survey 2026
- **Zimbabwe:** - STOP MDA survey 2026
- Rwanda
  - prevalence mapping and STOP MDA survey in 2026
- Kenya
  - MEDSCAN study in Western Kenya with 15000 tests validating mobile app 2025-2026
  - AMREF Test & Treat pilot 2025-2026
  - AMREF STOP-MDA survey 2026

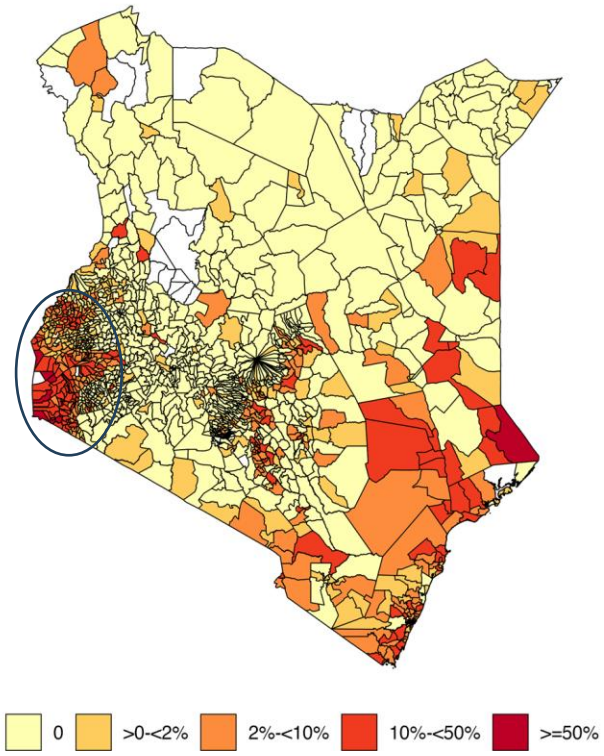
Field testing of POC-CCA

Rwanda: How use POC-CCA to progress towards interruption of transmission

Ladislas Nshimiyimana NTD Program manager at MOH Rwanda

- 2020: Used POC-CCA for mapping as prevalence of Schistosomiasis (1.7%)
  - Outcome helped to identify low prevalence infections (Trace positive were also treated)
- 2026: STOP-MDA program started in 2 districts
  - 14K test used in 174 villages all positive on KK also on POC-CCA
  - Outcome: able to detect cases we might otherwise miss and treat based on CCA results
- 2026: National impact survey surveillance -Sep/Oct26 10K test
  - KK planned at health facility lab (trained all lab technicians in IoT districts)
  - POC-CCA for a targeted groups with risk factors use in the remote settings
  - Advantage: : High risk households tested by POC-CCA (positive treated with PZQ)

Kenya: Experience with POC-CCA in national programs

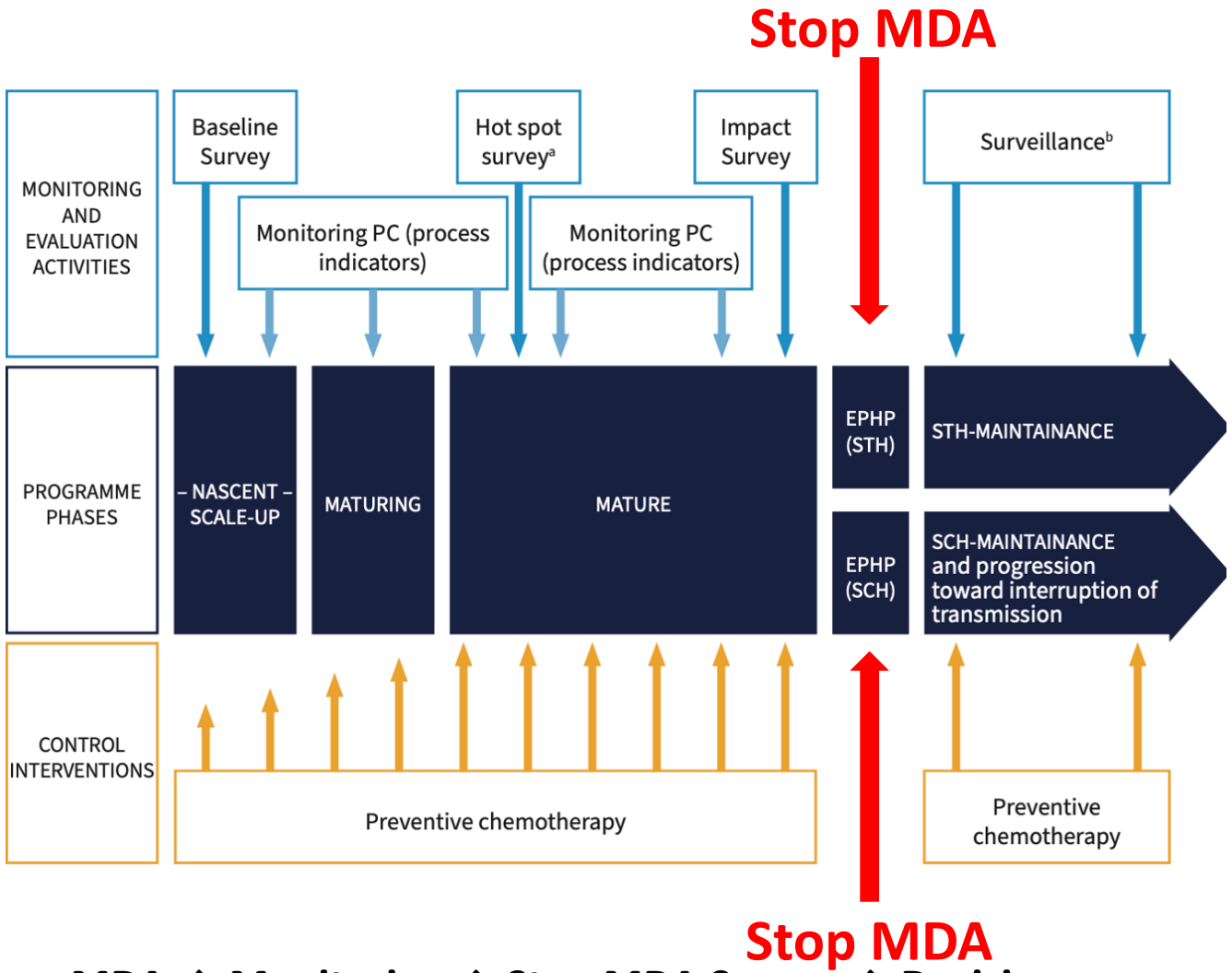


Wycliff Peter Omoni Head DVBNTD, Kenya

Stella Kepha, KEMRI

- MEDSCAN study in Western Kenya with 15000 tests validating mobile app **2025-2026**
- MOH Test & Treat pilot **2025**
- MOH STOP-MDA survey **2026**

Where does a Stop MDA Survey Fit in the MDA Decision Pathway and its nexus to WHO or National Frameworks?

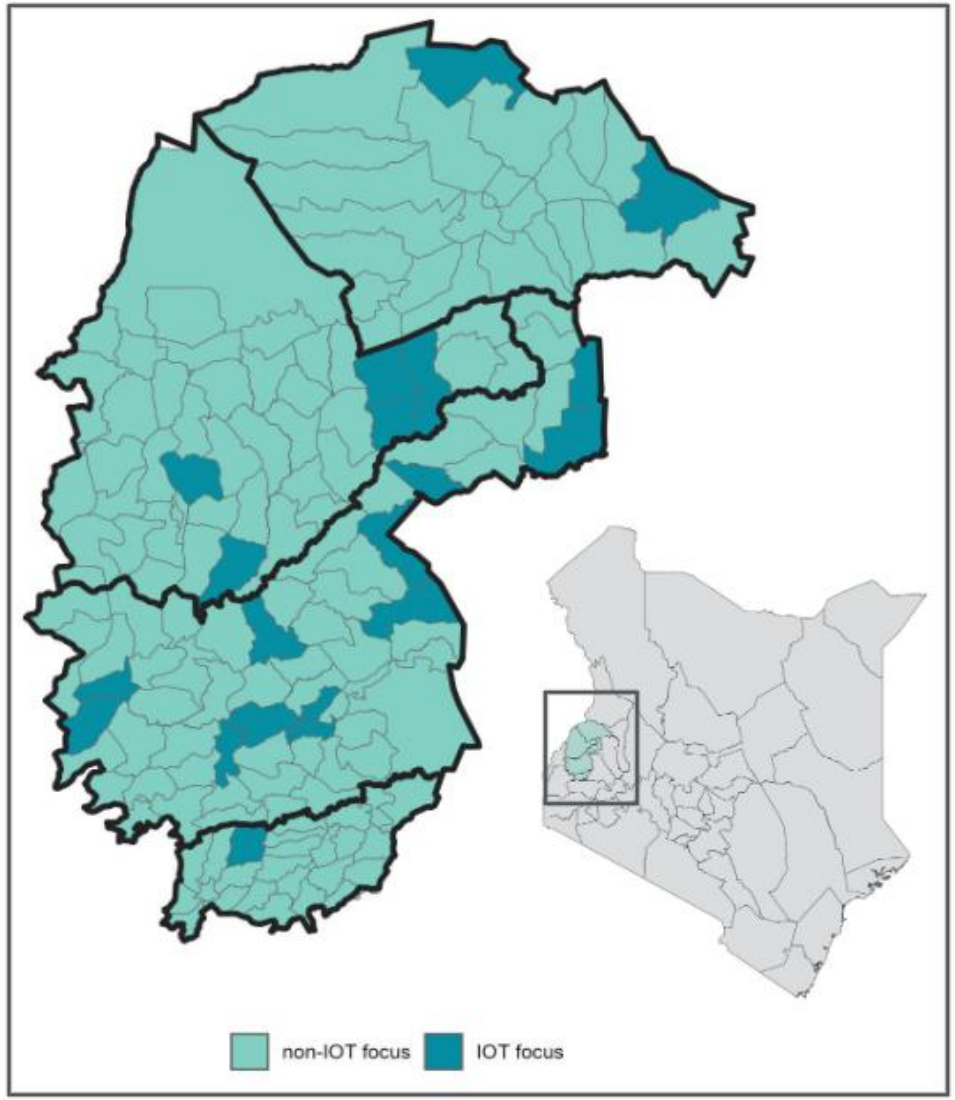


MDA → Monitoring → Stop MDA Survey → Decision

Link to WHO or National Decision Frameworks

Framework	Relevant to Stop MDA?	Notes
WHO Schistosomiasis Guideline (2022)	✓ Provides prevalence and intensity guidance	Sets treatment and evaluation benchmarks
Assessing schistosomiasis & STH M&E framework (2024)	✓ Guides timing & interpretation of impact surveys	Critical for Stop MDA Survey decisions
National NTD Master Plans & Policies	✓ Some include MDA stopping criteria	Varies by country; may adapt WHO guidance

Study sites and population



20 IoT Wards

- **Target Population**: PSAC (1-5 yrs), SAC (>5 to <18 yrs) and Adults (≥18 yrs)
- **Sampling Design**: Cross-sectional Community-based survey
  - Primary sampling unit (PSU) = Village
- **Sample Size**: Adapted from Precision mapping from SPPA protocol.
  - Min. 8 sites per EU/IU (double those in Precision Assessment).
  - Min. 22 participants per Target age-group per site/village (Min. *n* = 66)
- **Diagnostic Method**:
  - Kato-Katz (duplicate slides), POC-CCA (for *S. mansoni*)
- **WASH data:** Household Questionnaire
- **Quality Assurance & Documentation dossier**:

Test and Treat (5T) – Active Surveillance in Bungoma

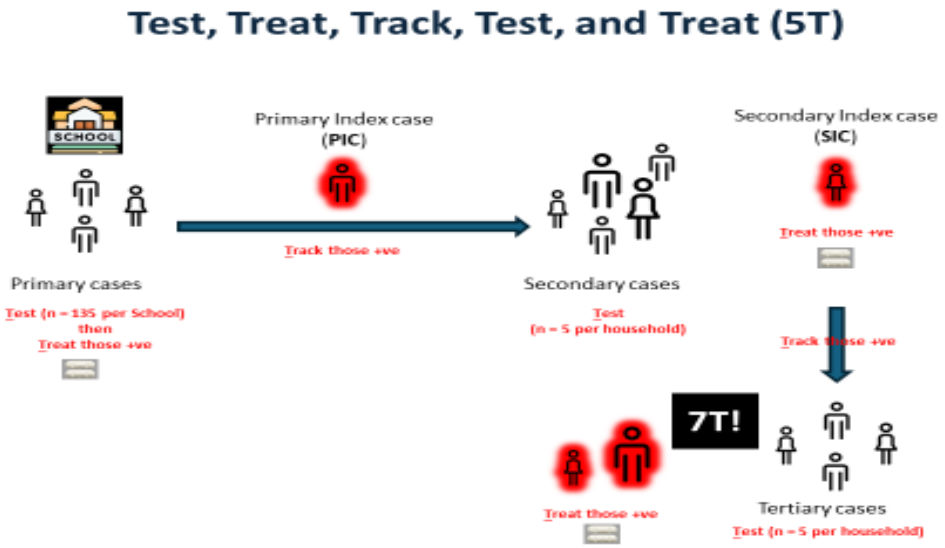
What Was Done:

- SCH Targeted testing in schools & communities in low-prevalence areas
- Treated confirmed cases and traced contacts

Key Findings:

- **Low Prevalence Confirmed**
  - Overall S. mansoni **prevalence: 2.1%** (27/1,269)
  - Prevalence among primary cases: 1.6% (19/1,186)
  - Secondary infection rate-7.8%, tertiary: 20%
- All secondary cases were male, median age 17
- Cost-effective compared to blanket MDA

Lesson: 5T critical for interruption of transmission chains where prevalence is low without mass drug use.



Potential benefits for POC-CCA

- Higher sensitivity, especially in low-prevalence settings
- Detects active infection (antigen-based)
- Simple, rapid, and field-friendly (urine-based)Improves mapping of residual transmission
- Supports programmatic decisions (impact assessment, MDA adjustment)

THANK YOU

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EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

ANNUAL MEETING OF
NTD PROGRAMME MANAGERS IN AFRICA

Field evaluations of a novel RDT to detect schistosomiasis

Vision for FIND's SCHISTOSOMIASIS EFFORT

FROM…

Complex, costly and timely diagnosis process

- Multi-day sampling, lab transfer, skilled reader to interpret results etc.

Over- or under treatment of affected communities

- Without precise mapping enabling strategic targeting, MDA campaigns are sub-optimal

Treatment exclusion of at-risk groups

- Although they are contributing to transmission, current MDA approach excludes adults and pre-school age children

Poor diagnosis and sub-optimal treatment strategy slow down efforts to reach goal

…TO

Rapid diagnostic testing

- For immediate assessment of prevalence in communities

Improved efficiency and costs of MDA campaigns

- Targeted MDAs for a focal disease

Expanded access to testing through better integration

- SCH screening and treatment integrated into non-NTD health programs
- SCH diagnosis integrated into PHC in high-burden countries

Easy-to-use test allows precision mapping and more effective interventions paving the way to sustainability

Current method of detection as recommended by WHO

CURRENT TECHNOLOGIES

	Microscopy	Dipstick	Antigen methods*
Sample type			
Method			 POC-CCA

*only works for S.*m* and at high-moderate intensity infections

WHO DTAG TPPs

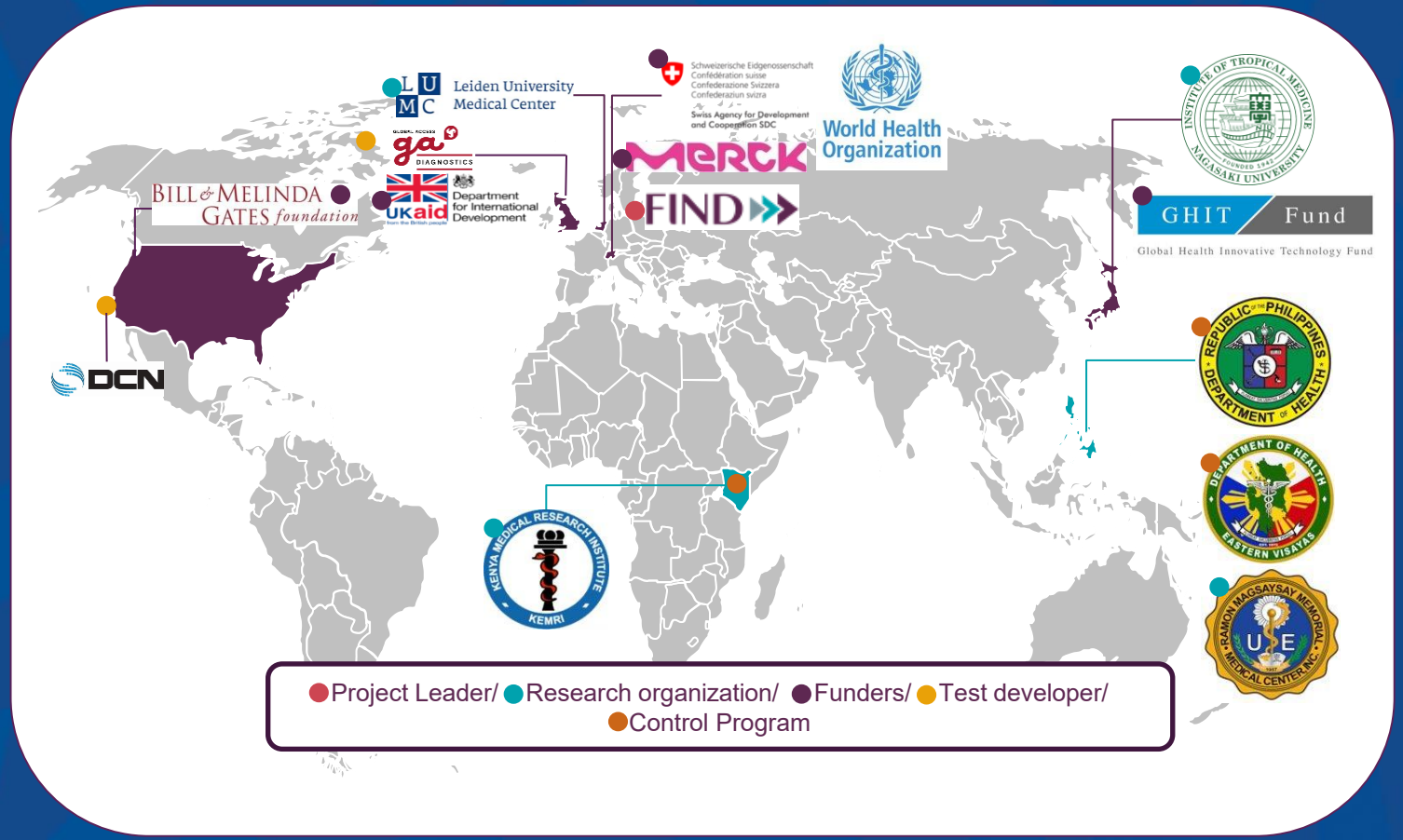
1 M&E

Intended use:

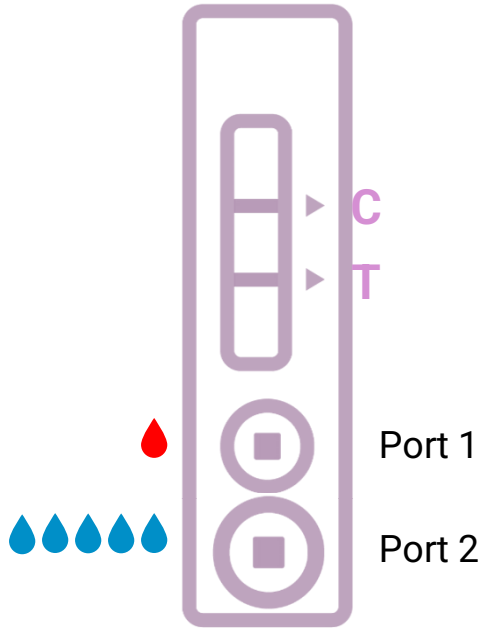
An in vitro point-of care test for the detection of analyte specific to S.*m* or S.*h* to aid in M&E of SCH control efforts.

	Min.	Ideal
Sensitivity	>60%	>75%
Specificity	>95%	>96.5%

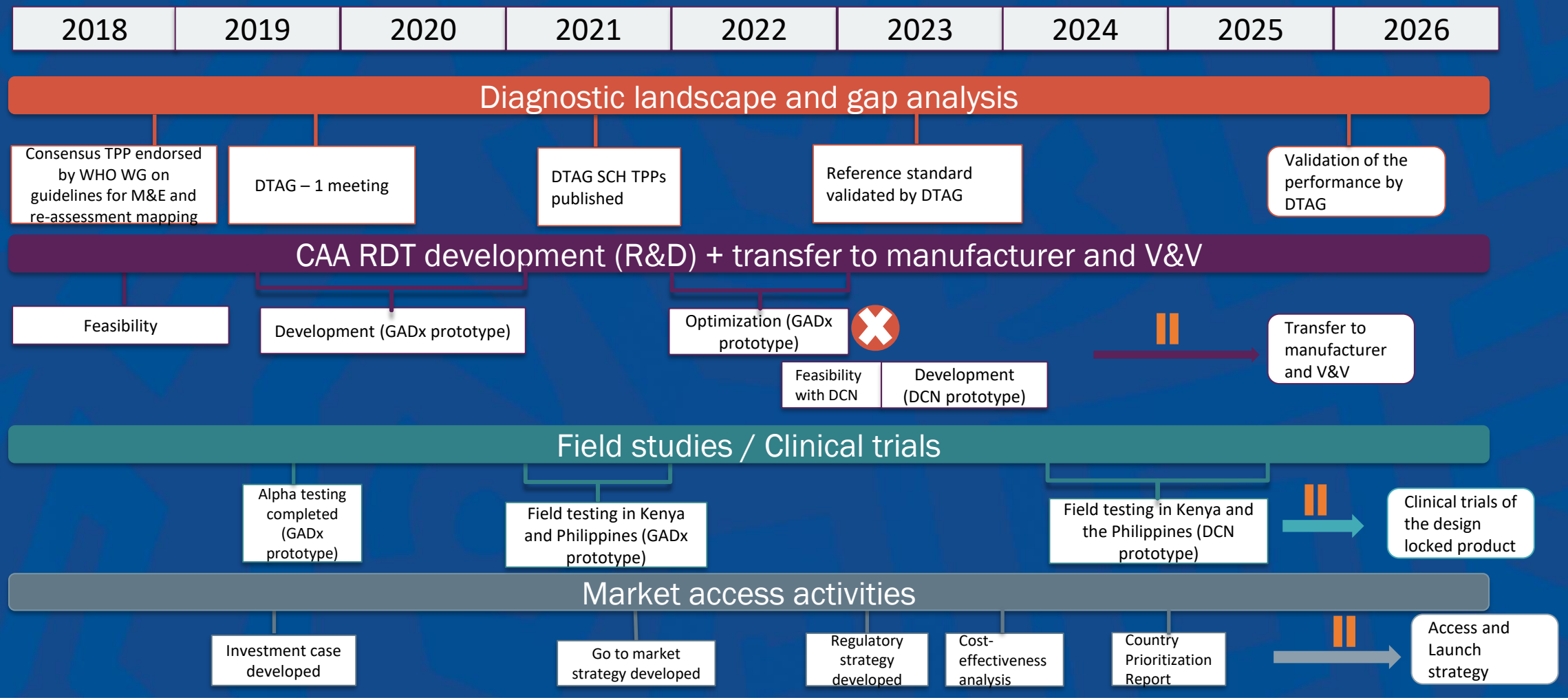
Background, partners and donors



Prototype design



Overall work conducted so far – what's next?



Validation of the composite reference by the DTAG SCH subgroup

4. Feedback from disease-specific and cross-cutting subgroups

During this session, the meeting heard updates from the chairs of the disease-specific and cross-cutting subgroups.

4.1 Disease-specific subgroups

4.1.1 *Schistosomiasis*

The Foundation for Innovative New Diagnostics (FIND) is in the process of attempting to define a composite reference standard for evaluating future schistosomiasis diagnostic tests. This work is being carried out in preparation for attempting to satisfy the TPP on monitoring and evaluation (1).

It is likely that a composite reference standard will be needed because current test formats (such as Kato–Katz and urine filtration) do not consistently achieve the required test sensitivity.

The schistosomiasis subgroup therefore proposes a composite reference standard comprising two days of microscopy for eggs, coupled with a day 1 PCR (polymerase chain reaction) test and a day 1 UCP-LF CAA (Schistosoma up-converting phosphor lateral flow circulating anodic antigen) assay.

The composite reference standard has been agreed and proposed by the schistosomiasis subgroup, although the proposal will likely not be optimal for the other TPP for schistosomiasis (the TPP relating to elimination of transmission and surveillance).

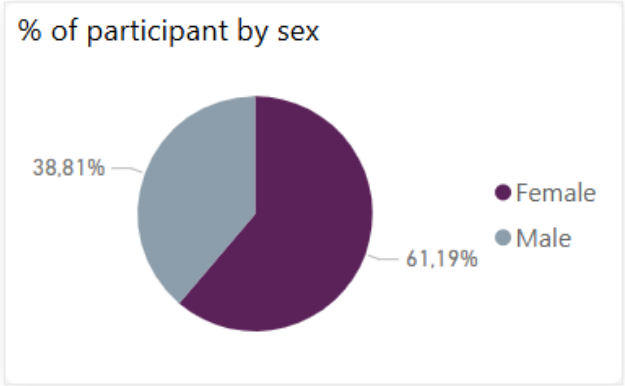
Field evaluations in KE and PHL

KENYA

Implementers

976
PARTICIPANTS ENROLLED

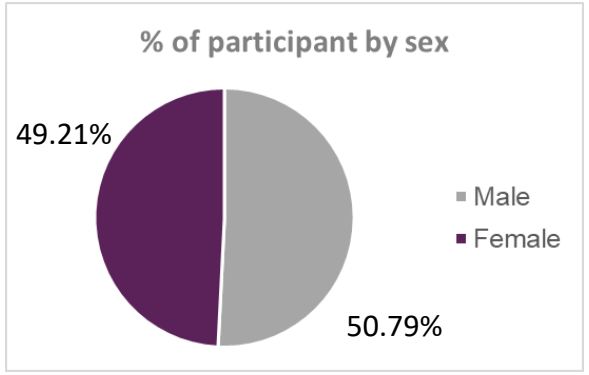
- 184 in Kijabe (non-endemic site)
- 396 in South Sakwa (S.*m* site)
- 396 in Mkongani (S.*h* site)



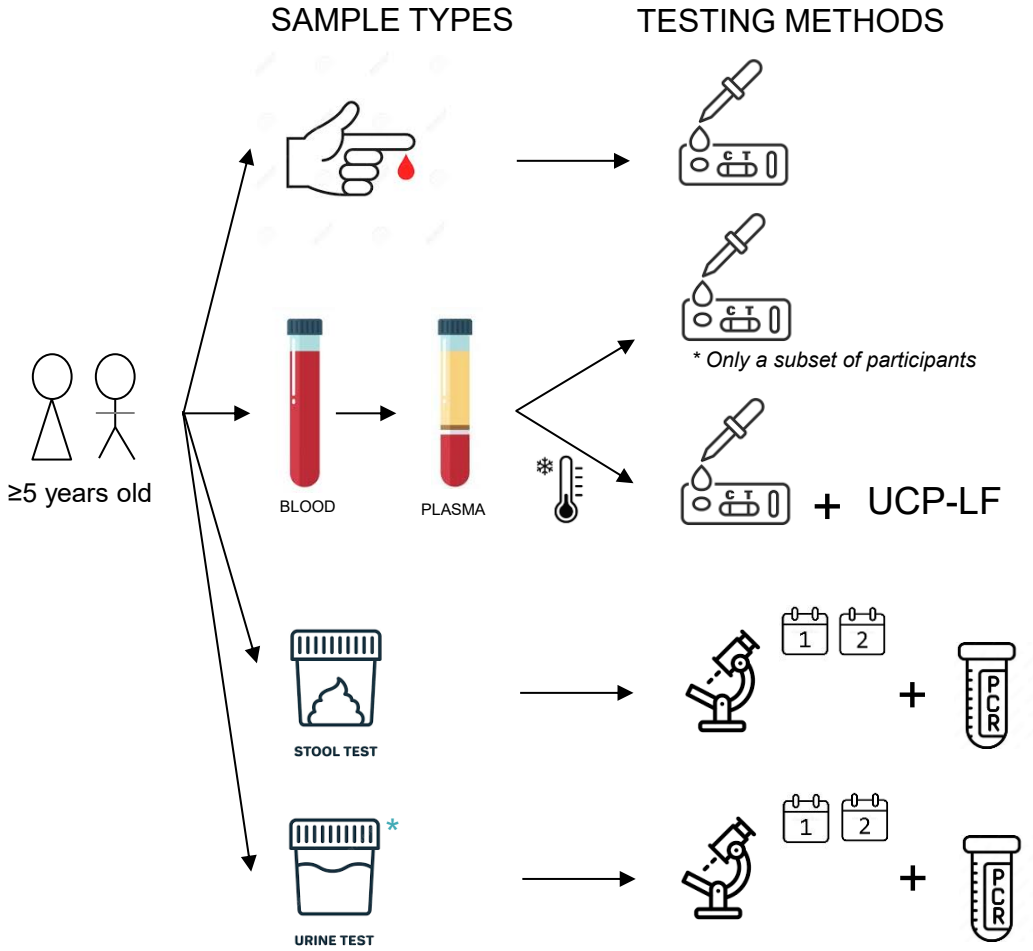
PHILIPPINES

580
PARTICIPANTS ENROLLED

- 184 in Patong (non-endemic site)
- 396 in Aringit (S.*japonicum* site)



STUDY PROTOCOL SUMMARY:



Anyone positive by microscopy for SCH and/or STH were offered treatment as per current treatment guidelines at the end of the study
** Only in Kenya*

SCH RDT – Composite Reference

Composite reference was used in this study as validated by the WHO DTAG SCH subgroup: 2-day microscopy, UCP-LF and real-time PCR

- **Positive** is considered when a positive result occurs by any of the test methods
- **Negative** is considered when a negative result is obtained by all test methods

		Composite Reference			Expected prevalence[3]
		Positive	Negative	**Total**	
KE	Kijabe (non-endemic)	1 (0.6%)	179 (99.4%)	**180***	**<1%**
KE	Mkongani (S.*haematobium*)	213 (53.9%)	182 (46.1%)	**395[1]**	**10 – 49.9%**
KE	South Sakwa (S.*mansoni*)	259 (61.7%)	127 (32.9%)	**386[2]**	**10 – 49.9%**
PHL	Patong (non-endemic)	26 (14.9%)	149 (85.1%)	**175[4]**	**<1%**
PHL	Aringit (S.*japonicum*)	139 (35.3%)	255 (64.7%)	**394[5]**	**43 %**

Reminder: WHO TPP performance criteria

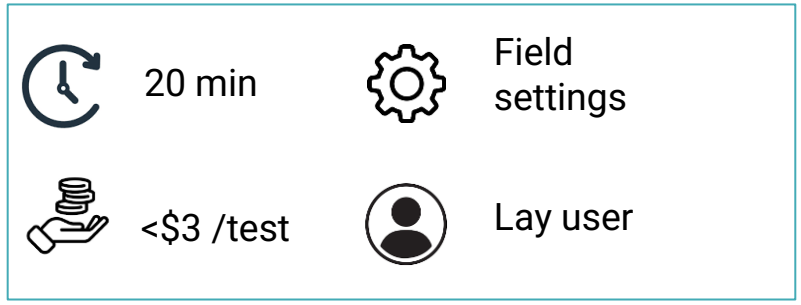
	Minimum	Ideal
Clinical Sensitivity	>60%	>75%
Clinical Specificity	>95%	>96.5%

*3 samples missing a qPCR result and 1 sample missing the UCP-LF CAA assay result
[1] 1 sample missing a urine sample for microscopy testing
[2] 9 samples were not processed as they had insufficient sample volume for qPCR analysis and 1 sample didn't have frozen plasma for UCP-LF CAA assay
[4] 7 samples had an invalid run on the RDT when using a finger prick but they were not repeated. 1 sample was missing either a day 1 or day 2 stool sample, and 1 participant had no RDT performed at all.
[5] 1 sample was missing a UCP-LF result and 1 sample didn't have a finger prick sample to run the RDT.

[3] – expected prevalence reported by ESPEN (https://espen.afro.who.int/maps-data/countries/kenya#sch--maps) by microscopy.

Results – for all 3 SCH species – clinical sensitivity

	Overall	Sensitivity (95% CI)
Finger prick	S.*mansoni* **(n=386)**	80.69% (75.45 – 85.04)
	S.*haematobium* **(n=395)**	54.93% (48.22 – 61.47)
	S.*japonicum* (**n=394**)	59.71% (51.4 – 67.5)



Sensitivity per intensity level of positive samples by microscopy	S.*mansoni*	S.*haematobium*	S.*japonicum*
Light	**n= 101**: 84.16% (75.81 - 90.01)	**n= 107**: 58.88% (49.41 – 67.74)	**n= 70**: 60% (48.29 – 70.67)
Moderate	**n= 47**: 100% (92.44 - 100)	N/A	**n= 20**: 85% (63.96 – 94.76)
Heavy	**n= 8**: 100% (67.56 - 100)	**n= 34**: 88.24% (73.38 – 95.33)	**n= 4**: 75% (30.06 – 95.44)
Overall performance on SCH positive by microscopy:	**n= 156**: 89.74% (83.99 - 93.59)	**n=141**: 65.96% (57.81 – 73.26)	**n= 94**: 65.96% (55.92 – 74.74)

Results –clinical specificity

	Overall	Specificity (95% CI)
Finger prick	Non-endemic site **(Kenya)**	99.44% (96.9 - 99.9)
	Non-endemic site **(Philippines)**	97.99% (94.25 - 99.31)

20 min

Field settings

<$3 /test

Lay user

Preliminary user feedback – field usability testing

✓ **All respondents agreed n= 6**

Instructions easily understandable	Compatible with field use	Suitable for non-lab technicians	Results easy to interpret	Facilitates user workflow
✓	✓	✓	✓	✓

⚠ **AREAS FOR IMPROVEMENT**

01 Clearer Band Labeling

Improve marking of control and test bands on the device for clearer visual distinction during result reading.

02 Descriptive Port Labels

Replace Port 1 / Port 2 labels with descriptive terms: "Sample Well" and "Buffer Well" for the final product.

What are the advantages of the RDT over microscopy?

Key TPP criteria	Minimum	Ideal	Microscopy	SCH CAA RDT
1.3+1.4 Lowest infrastructure + End user	Test performed under «zero infrastructure» conditions including but not limited to schools, CHC, HH and outdoor conditions. Test will be performed by health personnel, CHW and CV	Same	✗ Minimum ✗ Ideal	✓ Minimum ✓ Ideal
1.5 Training requirements	≤1 day for health personnel, community volunteers and lay people; testing job aid/instructions for use should be made available via the internet for download in addition to the instructions included with the test	Same	✗ Minimum ✗ Ideal	✓ Minimum ✓ Ideal
2.5 Sample type/Collection	Urine or whole blood from finger stick	Same	✗ Minimum ✗ Ideal	✓ Minimum ✓ Ideal
3.4 Time to results	<2h to developed test result *(From sample collection to result availability)*	<0.5h to develop test result	✓ Minimum ✗ Ideal	✓ Minimum ✓ Ideal
3.2 Diagnostic/clinical sensitivity	>60%	>75%	Range between 25-90%	S. man: 80.69%, (86.73% by LCA) S. hae: 54.93%, (64.37% by LCA) S. jap: 59.71%, (61.95% by LCA)
3.3 Diagnostic/clinical specificity	>95%	>96.5%	Range between 90-99%	Non-endemic (KE) 99.44% (96.9 - 99.9) Non-endemic (PHL) 97.99% (94.25 - 99.31)
3.6 Throughput	≥ 7 individuals tested/h per tester	≥ 10 individuals tested/h per tester	✗ Minimum ✗ Ideal	✓ Minimum ✓ Ideal
3.8 Ease of use	≤3 timed steps, ≤10 user steps, instructions for use should include diagram of method and results interpretation. Must be able to use in an unprotected external environment	≤1 timed steps, ≤5 user steps, instructions for use should include diagram of method and results interpretation. Must be able to use in an unprotected external environment	✗ Minimum ✗ Ideal	✓ Minimum ✗ Ideal
5.1 Target pricing per test (depends on manufacturer and vol.) so instead look at estimated COGs)	< US$ 3	< US$ 1	✓ Minimum* ✓ Ideal	✓ Minimum ✓ Ideal

Key takeaway and recommendations

1. For S.*mansoni* and S.*haematobium*, we believe the test offers clear advantages over the current tool when evaluated comprehensively. Therefore, we recommend proceeding with design-lock, validation, and technology transfer for these 2 SCH species.

2. We recommend proceeding with another field evaluation for S.*japonicum* to confirm the good performance of the SCH CAA RDT and to rule out methodological differences. Site selection should be identified based on recent mapping data.

3. Further analysis might be needed to better evaluate cut-offs.

4. We have received support from WHO DTAG SCH sub-group (January 2026) who have reviewed the results and have encouraged us to proceed with the steps outlined above.

Thank you all

FIND - NTD
Sarah Hingel
Thierry Ramos
Helen Bokea

CTU
Rossella Baldan
Emilie Alirol
Pamela Nabeta

Data
Mikaela Watson
Dorcas Akach
Berra Erkosar

Tech&Dev
Olga Ordeig
Serafina Calarco

GMO
Wachira Waruhú

Biobanking
Warren Fransman
Imane El Idrissi

P&L
Tomas Cristovao
Mariana C Torrez

LUMC
Ron Hokke
Paul Corstjens
Stan Hilt

NUITM
Shinjiro Hamano
Noriko Kobayashi
Miho Sassa

Merck
Beatrice Greco

Bob Suva

NHM
Bonnie Webster
John Archer

KEMRI
Sammy Njenga
Henry Kanyi
Wycliff Omondi
+ local team

UERM
Jennifer Nailes
Paola Mikaela Alpay
+ local team

DCN
Sean McHugh
Xiaofang Bian

University of Surrey
Joaquin Prada

Funders

GHIT Fund
Global Health Innovative Technology Fund

Bill & Melinda Gates foundation

Merck

Partners

LUMC

Institute of Tropical Medicine, Nagasaki University

Kenya Medical Research Institute, KEMRI

Ramon Magsaysay Memorial Medical Center, Inc.

DCN DX

Natural History Museum

Republic of Kenya, Ministry of Health

Department of Health, Eastern Visayas

THANK YOU

13-16 April 2026

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EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

ANNUAL MEETING OF
NTD PROGRAMME MANAGERS IN AFRICA

SCH CAA RDT field evaluation: strengths and limitations

Strengths and limitations

Strengths	Limitations
1. Ease-of-use • Simple, step-wise procedure • Minimal training requirement • Lightweight cassette, field applicability • Can be used at the peripheral health facilities	**1. Does not detect STH** • Many programmes rely on Kato-Katz for STH M&E
2. Time to results • Results available in 20 minutes	**2. Semi-quantitative results** • Potential inter-reader variability
3. Stability • Individual foil-sealed pouches with desiccant protect RDT against humidity	**3. Programmatic requirements for transitioning from microscopy to RDT** • Staff training, quality assurance • Logistics around implementation

16.1B. VL RDT requirement in eastern Africa – a compelling case of urgency

Parallel Session B – 16.2
From Forecasting to Action: Leveraging Multi-Year Planning to Support Sustainable NTD Programmes toward 2030
14:00 - 15:30

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EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

ANNUAL MEETING OF
NTD PROGRAMME MANAGERS IN AFRICA

From Forecasting to Action: Leveraging Multi-Year Planning to Support Sustainable NTD Programmes toward 2030

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ANNUAL MEETING OF NTD PROGRAMME MANAGERS IN AFRICA

From Forecasting to Action: Leveraging Multi-Year Planning to Support Sustainable NTD Programmes toward 2030

John Francis / JSI

13-16 April 2026

Lilongwe, Malawi

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African Region

ESPEN
EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

Recent Challenges in Predicting Future Demand for NTD Medicines

Inconsistent demand from year to year due to;

- Changing endemicity as countries move towards elimination.
- New treatment guidelines can result in large and rapid shifts in future demand

Changing NTD funding landscape;

- Reduced donor funding that may affect MDA implementation
- Increase in integrated campaigns, government funding and local procurement

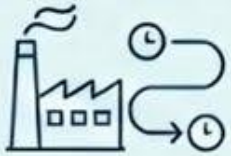
Multi-Year Forecasting Provides Benefits for All

Empowers local health programs

Equips Ministries of Health with insights to mobilize resources, fill gaps, and strengthen long-term coordination. Supports 2-3 year government procurement planning.

Improves Long Term Planning

Aligns ministries, donors and suppliers around a shared plan, helps countries to coordinate across programs and plan for disease elimination.

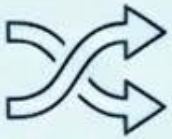


Aligns with manufacturing timelines

Provides pharmaceutical partners with vital advance notice for API procurement (2-3 years), staffing, capacity optimization, and budgeting.

Reduces manufacturing costs and delays

Predictable demand avoids costly overproduction (storage, wastage) and underproduction (expedited shipping). Enables shorter delivery times.



Allows supply chain to adapt to large shifts

Alerts stakeholders early to changing endemicity or new treatment guidelines (e.g., pediatric praziquantel), allowing the supply chain time to respond.

Strategic Value of Multi-Year Forecasting

Supports long-term planning

- Helps countries anticipate future medicine needs and interpret changes in demand linked to elimination progress, funding delays, or survey gaps.

Prevents supply chain shocks

- Gives partners and manufacturers time to align production, funding, and delivery cycles, avoiding shortages or wastage.

Improves coordination

- Creates a shared roadmap for ministries, donors, and suppliers working on different planning timelines.

Strengthens funding advocacy

- Highlights potential funding gaps early, allowing partners to mobilize resources before they become urgent.

Enhances data quality and accountability

- Encourages countries to document assumptions, validate data, and engage partners in transparent planning.

A one-year demand is a snapshot — **a three-year forecast is a strategy for countries to plan towards elimination.**

Multi-year forecasting complements annual requesting

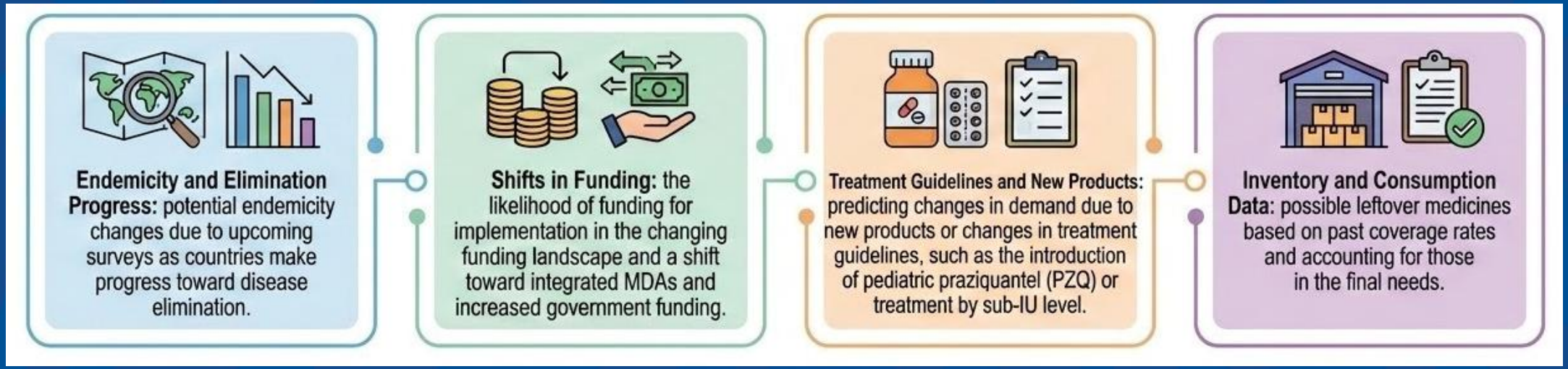
	JRSM Annual Forecast	Multi-Year Forecast
Purpose	Request exact quantity of medicines to be supplied for the next 12 months	Estimate changes in demand so the supply chain has time to respond
Key Question	*What, how much, and when do we need the medicines?"*	*What will our medicine needs and costs look like in **3-5 years**, and how do we prepare?*
Key Features	Operational, actionable, higher accuracy	Strategic, directionally accurate, supports advocacy and preparedness

They solve different problems but are directly linked. The long-term forecast supports planning and advocacy, and the annual request puts the plan into action.

Multi-year Forecasting Methodology

A multi-year forecasting tool has been developed using Excel.

The tool uses the same methodology as the Joint Request for Selected Medicines (JRSM), forecasters are asked to consider the factors below to estimate the population requiring MDA and the quantities of medicines required for future years.



Multi-year Forecasting Outputs

Output tables present aggregate and disaggregate information by age groups, disease and funding likelihood.

Countries can compare with past shipment quantities to check accuracy and direction of demand (increasing or decreasing or erratic).

Countries can use disaggregated data for planning and advocacy, e.g.

- quantities covered by donation program but low likelihood of implementation funding
- quantities not covered by donations that may require additional resources or local procurement
- etc.

Treated Population by Medicine and Disease

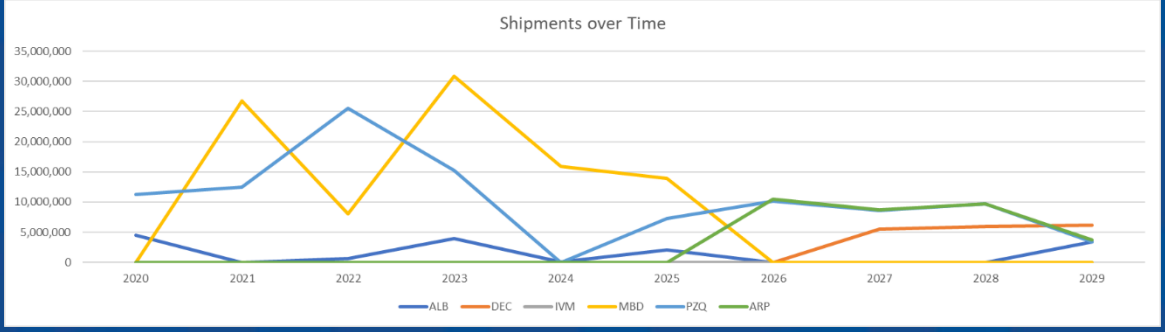
Medicine	Disease	2027			2028			2029	
		Population	Pop * Rounds	Tablets	Population	Pop * Rounds	Tablets	Population	Pop * Rounds
ALB	LF	2,115,938	2,115,938	2,115,938	2,168,837	2,168,837	2,168,837	1,842,108	1,842,108
ALB	STH	877,097	1,242,762	1,242,762	899,023	1,273,831	1,273,831	921,499	1,432,293
DEC	LF	2,115,938	2,115,938	5,289,845	2,168,837	2,168,837	5,422,093	1,842,108	1,842,108
IVM	LF	2,115,938	2,115,938	5,924,626	2,168,837	2,168,837	6,072,744	1,842,108	1,842,108
IVM	Oncho	2,535,012	1,609,451	4,506,463	2,598,385	1,649,685	4,619,118	2,298,131	1,371,954
MBD	STH	580,724	1,057,649	1,057,649	595,238	1,084,082	1,084,082	610,121	1,111,188
PZQ	SCH	1,103,464	1,103,464	2,206,928	1,231,115	1,231,115	2,462,230	1,228,855	1,228,855
ARP	SCH	0	0	0	0	0	0	0	0

Planned MDA Tablets by Age Group

Medicine	2027							2029	
	Total	PreSAC	SAC	SAC + Adults	All Adults	WRA	Other Adults	Total	PreSAC
ALB	0	512,203	730,559	2,115,938	0	0	0	0	525,006
DEC	0	0	0	5,289,845	0	0	0	0	0
IVM	0	0	0	10,431,089	0	0	0	0	0
MBD	0	0	0	0	0	1,057,649	0	0	0
PZQ	0	0	2,206,928	0	6,922,779	0	0	0	0
ARP	0	0	0	0	0	0	0	0	0

Planned MDA Tablets by Likelihood

Medicine	2027			2028			2029		
	High	Medium	Low	High	Medium	Low	High	Medium	Low
ALB	0	0	3,358,700	0	0	3,442,668	0	0	3,274,401
DEC	0	0	5,289,845	0	0	5,422,093	0	0	4,605,270
IVM	0	0	10,431,089	0	0	10,691,862	0	0	8,999,374
MBD	0	0	1,057,649	0	0	1,084,082	0	0	1,111,188
PZQ	0	0	2,206,928	0	0	2,462,230	0	0	2,457,710
ARP	0	0	0	0	0	0	0	0	0



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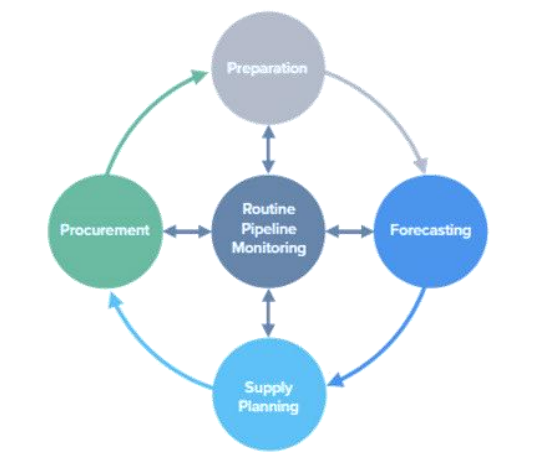
Multi-year Forecasting Outputs

Lessons Learned

- Disease leads / technical leads and implementing partners in country should be engaged to support long term planning of MDAs and surveys and **accurately complete** a forecast, it can not be done solely by supply chain and M&E advisors.
- Country teams need to be able to **critically analyze** the results to ensure they are realistic, rational and reflect their elimination goals.
- Forecasts should be **updated regularly** (ideally every six months) as the situations changes to reflect the realities on the ground and adjust forecast as needed. Assumptions should be well documented.



Next Steps

- Excel Tool has been refined based on feedback provided last year
- Create a user friendly web version of the tool that can utilize data in ESPEN Portal to validate forecast assumptions
- Create support materials such as videos and manuals
- Expand the number of countries routinely completing multi-year forecasts

THANK YOU

13-16 April 2026

Lilongwe, Malawi

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EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

ANNUAL MEETING OF
NTD PROGRAMME MANAGERS IN AFRICA

ANNUAL MEETING OF NTD PROGRAMME MANAGERS IN AFRICA

From Forecasting to Action: Leveraging Multi-Year Planning to Support Sustainable NTD Programmes toward 2030

Dr Clarer Jones Mwansasu
NTD Program Manager
Ministry of Health,
Tanzania

15 April 2026

Lilongwe, Malawi

African Union

World Health Organization
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Experiences In Using The Multi-year Forecasting Tool

Approach adopted to carry out Multi Year Forecast

What we have been doing

Team Approach

Multi-stakeholder engagement:

-Ministry of Health (MOH)- NTDCP, PSU

-PMO-RALG

-WHO Country Office

- Health Facility Representatives (end users)
- Implementing partners

Collaborative planning and validation

Clear roles across

Data Preparation

Collect inventory data:

- Stock on hand
- Quantities distributed
- Losses and adjustments

Collect survey data

- Surveys implemented
- Planned surveys

Validate data before workshop

Ensure completeness and consistency

Structured sessions

Organize structured sessions (approx. 5 sessions):

Use pre-filled MYF tool (semi-automated)

Share materials in advance

Align stakeholders on expectations

Review assumptions:

Population targets (possible reduction)

Survey status

Availability of funding

Ensure data readiness before

The Multi-year Forecasting Tool Overview

IU Information			MDA History	2026 (Set in JRSM)						
Country	District	IU_Id	Effective MDAs	Endemicity	Population	PreSAC Pop	SAC Pop	WRA Pop	Other Adults Pop	Surveys Pl
Tanzania	Arusha City Council		0	99	0	0	0	0	0	
Tanzania	Arusha District Council		0	99	0	0	0	0	0	
Tanzania	Karatu District Council		0	99	0	0	0	0	0	
Tanzania	Longido District Council		0	99	0	0	0	0	0	
Tanzania	Meru District council		0	11	0	0	0	0	0	
Tanzania	Monduli District Council		0	99	0	0	0	0	0	
Tanzania	Ngorongoro District council		0	11	0	0	0	0	0	

		2027				Included in 2027				
d 0	Rounds Planned	Expected Endemicity 1	Surveys Planned 1	MDAs Planned 1	Funding Likelihood 1	PreSAC 1	SAC 1	WRA 1	Other Adults 1	Expected
0	0	99	0	No MDA	No MDA	No	No	No	No	
0	0	99	0	No MDA	No MDA	No	No	No	No	
0	0	99	0	No MDA	No MDA	No	No	No	No	
0	0	99	0	No MDA	No MDA	No	No	No	No	
0	0	11	0	Round 1 Only	High	Yes-ALB	Yes-AL	Yes-ME	No	
0	0	99	0	No MDA	No MDA	No	No	No	No	

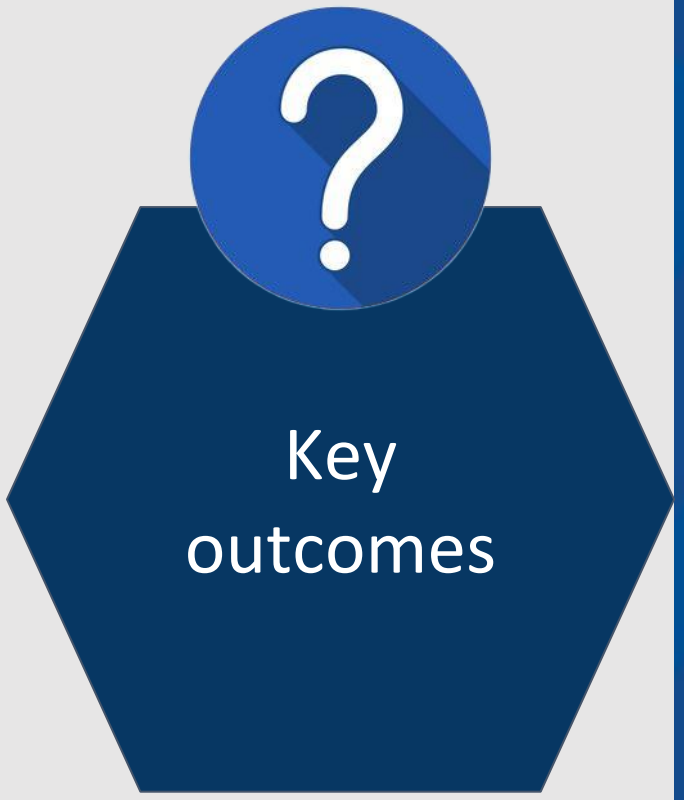
- Excel tool that mirrors the JRSM methodology for inputs (constants, disease specific and summary sheets)
- Based on next year approved JRSM plus three forecasted years
- Incorporates SCH Workbook v6 if used by country
- Uses the same assumptions as ESPEN Projections

Experiences In Using The Multi-year Forecasting Tool

Assumptions around multi year forecasting

Target Population	Number of IUs & MDAs frequency	Commodities required	Funds availability
One vital assumption is the population to be served -Age group -Number of people - -Previous coverage reports This also informs the resources allocation	MDA plans are made around funds availability which largely depends on -Expert/TWG recommendations -Partners Support -Government Fund commitment	Some assumptions are made around -is it integrated MDA or not -Previous consumption and wastage reports -expected target population including age group and number	MDAs plans are made around funds availability which largely depends on -Government directives -Councils planned budget -Probability of changes on financial commitments -Partners support

Experiences In Using The Multi-year Forecasting Tool

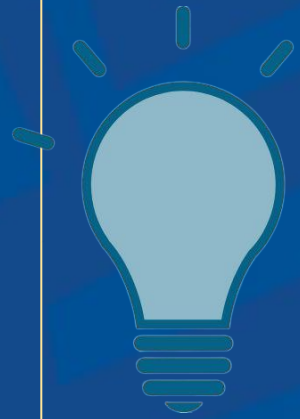


1. Commodity requirements for three years
    a. Disaggregated by disease,age group and funding availability
    b. Comparison with previous shipments

2. Proposed surveys for the next three years

3. Funding gap for MDA implementation

4. Validated program and supply data
    a. Agreed population targets
    b. Verified inventory status
5. Improved coordination across stakeholders



Experiences In Using The Multi-year Forecasting Tool

MYF Results

Outputs

ITEM	Demand 2027	Demand 2028	Demand 2029
Albendazole Tab	11,272,757	10,541,930	12,183,735
Ivermectin Tab	33,798,747	27,851,903	23,059,912

- Data for albendazole accounts for IUs that are doing MDAs once in 24 months, thus shows decrease in 2028 and increase again in 2029
- Endemic IUs for Oncho to decrease from 25 to 18 in 2029 hence the decline in commodity requirements- implies elimination progress

Funding Advocacy

Taking Advantage Of Forecasts

Rationale for Advocacy

Fragmented planning previously limited **credible funding requests**

Misalignment between **commodity needs, funding cycles, and MDA timelines**

Limited evidence to engage **government and partners strategically**

Inputs from MYF on funding advocacy

Consolidated **multi-year commodity forecasts (3-years)** across all NTDs
Generated **quantified national needs** (by disease, region, population)

Linked forecasts with:

- MDA schedules
- Epidemiological data
- Program scale-up targets

Produced scenario-based projections:

- Full funding vs partial funding scenarios
- Impact of delayed funding on coverage and wastage

Translation: - Advocacy Products

MYF outputs were converted into:

- **Investment Cases:** Costed commodity needs aligned with elimination targets
- **Policy Briefs:** Evidence-backed justification for domestic financing
- **Partner Engagement Packages:** Data-driven presentations
- **Quantification Reports**
  Used in joint planning forums (e.g. national TWGs)

MYF can transforms forecasting into a strategic advocacy instrument, enabling data-driven resource mobilization and program sustainability.

Taking Advantage Of Forecasts

Funding Advocacy

Key Advocacy msg derived from MYF	Strategic Value
Clear **funding gaps** vs required commodities	Shift from reactive requests → **proactive**, evidence-based advocacy
Demonstrated cost-efficiency for production planning	MYF tool positioned as a decision-support and negotiation tool, **not just** a forecasting tool
Evidence of **potential wastage reduction** with aligned supply planning	
Justification for **integrated MDAs** and synchronized campaigns	

"MYF can transforme forecasting into a strategic advocacy instrument, enabling data-driven resource mobilization and program sustainability."

Key Challenges

Data Limitations

Incomplete or inconsistent population, coverage, and consumption data

Reliance on assumptions where real-time data is lacking

Weak linkage between service data and commodity consumption

Fragmented Systems

Limited interoperability between:

- DHIS2 (service data)
- eLMIS (logistics data)

Parallel data streams reduce accuracy of forecasts and advocacy credibility

Technical Capacity

Inadequate capacity at the subnational level, thus MYF done at the central level

"Addressing these challenges is essential to unlock MYF's full potential as both a forecasting and strategic advocacy tool."

Lessons Learned

Data Quality Determines advocacy strength

Reliable forecasts depend on **accurate epidemiological, population, and consumption data**

Weak data reduces credibility in high-level advocacy discussions

Forecasting alone is not sufficient

MYF outputs must be **translated into clear, decision-oriented messages**

Advocacy requires **simplified narratives**, not just technical projections

Early Stakeholder Engagement Is Critical

Involving **MOH, PMO-RALG, partners, and donors early** improves ownership

Joint validation increases **trust and acceptance of forecasts**

Continuous Updating Is Necessary

Forecasts quickly become outdated without:

- Routine data updates
- Post-MDA consumption reviews

MYF should be treated as a **living tool**, not a one-time exercise

"The effectiveness of MYF lies not in the tool itself, but in how its outputs are translated, validated, and continuously used for strategic decision-making."

Moving forward…

Strengthen Data Foundations

- Institutionalize routine data validation
- Integrate service and logistics data from:DHIS2, eLMIS
- Use post-MDA reviews to continuously refine assumptions

Strengthen Translation into Advocacy Products

- Convert MYF outputs into Policy briefs, Donor engagement packages, Costed scale-up scenarios
- Simplify messaging for non-technical decision-makers

Build Capacity at All Levels

- Train national and subnational teams on MYF tool use, Data interpretation and Advocacy messaging
- Reduce dependency on central-level expertise

Position MYF as a Strategic Decision Tool

Move beyond forecasting → use MYF for:

- Investment case development
- Funding gap analysis
- Program prioritization

Align with National and Donor Planning Cycles

Synchronize MYF updates with:

- Government budgeting timelines
- Donor funding windows

Ensure forecasts inform resource allocation decisions in real **time**

Ensure Continuous Updating and Use

Treat MYF as a living tool:

- Regular updates after each MDA cycle
- Continuous use in planning and review meetings

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13-16 April 2026
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ANNUAL MEETING OF
NTD PROGRAMME MANAGERS IN AFRICA

ANNUAL MEETING OF NTD PROGRAMME MANAGERS IN AFRICA

Des Prévisions à l'Action : Tirer Parti de la Planification Pluriannuelle pour Soutenir Les Programmes De Lutte Contre MTN à l'Horizon 2030

Dr Kalenga Jean,
MOH/RDC

13-16 avril 2026

Lilongwe, Malawi

African Union

World Health Organization
African Region

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EXPANDED SPECIAL PROJECT FOR ELIMINATION OF NEGLECTED TROPICAL DISEASES

Expérience d'utilisation de l'outil de prévision pluriannuelle

Processus et approche

- Le nouvel outil de prévision pluriannuelle (MYF) a été briefé par le conseiller technique JSI auprès des staff impliqués au sein de la Direction du Programme;
- La Direction du Programme et JSI ont impliqué des partenaires de mise en œuvre UFAR et CBM et les informations sur le financement ont été confirmées et collectées
- Les prévisions ont été réalisées dans une réunion d'un groupe de travail spécifique assigné par le Directeur du Programme
- Ont participé à l'exercice : Le chef de l'UGD, la cheffe et la pharmacienne de l'UGM, le conseiller chaine d'approvisionnement du projet SCTSM de JSI.

Les données MTN nécessaires à la planification pluriannuelle ont été rassemblées (données de population ,endémicité , enquêtes réalisées extraites du draft du JRSM 2026)

Expérience d'utilisation de l'outil de prévision pluriannuelle

L'équipe a pris en compte les hypothèses suivantes déjà intégrées dans l'outil pour réaliser la prévision , mais en y apportant ses feedback:

Les ZS (IU) qui ont atteint la maturité du nombre de traitements pour la LF ne sont pas prévues pour le traitement, en attendant leur enquête d'impact.
Résultats:

Produits MTN-CTP		2027	2028	2029
Albendazole (ALB)	Nouveaux envois nécessaires	62 266 320	59 300 465	53 151 381
Ivermectine (IVM)	Nouveaux envois nécessaires	162 092 412	141 506 653	146 176 365
Praziquantel (PZQ)	Nouveaux envois nécessaires	13 139 833	29 709 961	27 588 344

Prévisions et opportunités:

Comment les données tirées de l'outil de prévision pluriannuelle ont produit des éléments de plaidoyer

REPUBLIQUE DEMOCRATIQUE DU CONGO

MINISTERE DE LA SANTEPUBLIQUE HYGIENEET PREVOYANCE SOCIALE

SECRETARIAT GENERAL A LA SANTE PUBLIQUE ET HYGIENE

DIRECTION DE SURVEILLANCE EPIDEMIOLOGIQUE

PROGRAMMES DE LUTTE CONTRE LES MALADIES TROPICALES NEGLIGEES

Plan Directeur National de Lutte contre les Maladies Tropicales Négligées 2026-2030

1.4.2.6.Prevision pluriannuelle des besoins en medicaments des campagnes de DMM

Tableau n°XIXII ; Cout d'achat et de la chaine logistique des principaux medicaments MTN-CTP

Medicaments MTN-CTP	Libellé	2027	2028	2029
Albendazole comprimés 400mg (ALB)/Filariose lymphatique (Elephantiasis) ,Verminoses et Oncho	Nouveaux envois nécessaires (en cés)	62 266 320	59 300 465	53 151 381
	Valeur medicaments Exw ($)	1 245 326,41	1 186 009,29	1 063 027,61
	Cout logistique ($)	*545 453*	*519 472*	*465 606*
	Cout outils de gestion (Registre de 50 pages)	*264 323*	*264 323*	*264 323*
	Valeur totale produit ($)	*2 055 102*	*1 969 804*	*1 792 956*
Ivermectine comprimé 3mg (IVM)/Onchocercose (Cecité des rivieres)	Nouveaux envois nécessaires (en cés)	162 092 412	141 506 653	146 176 365
	Valeur Exw ($)	34 039 406,44	29 716 397,20	30 697 036,72
	Cout logistique ($)	*14 909 260*	*13 015 782*	*13 445 302*
	Valeur totale produit ($)	*48 948 666*	*42 732 179*	*44 142 339*
Praziquantel comprimés 600mg (PZQ)/Schistosomiase (Bilharziose)	Nouveaux envois nécessaires (en cés)	13 139 833	29 709 961	27 588 344
	Valeur Exw ($)	1 501 094,50	3 394 065,96	3 151 692,46
	Cout logistique($)	*657 479*	*1 486 601*	*1 380 441*
	Valeur totale produit ($)	*2 158 574*	*4 880 667*	*4 532 134*
RDC	*Valeur Totale Annuelle ($)*	*53 162 342*	*49 582 650*	*50 467 429*
	Valeur medicaments Exw ($)	*36 785 827*	*34 296 472*	*34 911 757*
	Cout chaine d'approvisionnement ($)	*16 112 192*	*15 021 855*	*15 291 349*
	Cout outils de gestion (Registre de 50 pages)	*264 323*	*264 323*	*264 323*

La prevision pluriannuelle de besoins en principaux medicaments de la campagne e distribution de masse contre l'onchocercose, fillariose lymphatique, schistosomiase et geohelminthiase, s'inscrit dans la

Présidence de la République (Coordination de la Couverture Santé Universelle)

- **Intégration du PNLTM-CTP dans les équipes de révision des politiques qui définissent le paquet minimum CSU**
- **Révision de la liste des médicaments essentiels de base dans le cadre de la CSU pour intégrer ceux de lutte contre les MTN y compris les 3 des MTN-CTP objet de la prévision pluriannuelle**
- **Intégration des médicaments contre les MTN sur la liste des produits à prendre en charge par le gouvernement .Notamment le PZQ pour adultes, certaines enquêtes** Programme n'integrerde plaidoyer sera menée afin de mobiliser d'autres partenaires potentiels pour l'achat.

Leçons apprises

L’outil aide à programmer en avance les besoins en médicaments, à mener le plaidoyer concernant leur logistique,

Défis rencontrés

L’outil ne prend pas en compte le financement des enquêtes contrairement a celui de la DMM.

L’outil se base sur les données du JRSM en cours, alors que son approbation peut prendre du temps et les prévisions varieront selon que les données du JRSM seront entrain de changer

Recommendations

Améliorer la présentation des résultats de l'outil en intégrant des informations financières (valeurs) et logistiques (poids, volumes,ect) utiles pour une compréhension facile aux parties prenantes et surtout pour un plaidoyer facile.

MERCI

13-16 avril 2026

Lilongwe, Malawi

Poster Session

16:00 - 17:00

End of Day 3

We resume tomorrow at 8:30