

Eswatini Neglected Tropical Diseases Master Plan

2023 - 2027

Draft - 2022

Preface

Neglected tropical diseases (NTDs) are those diseases that generally afflict the world's poor and historically have not received as much attention as other diseases. NTDs tend to thrive in developing regions of the world, where water quality, sanitation, and access to health care are substandard. They are preventable and can be controlled. An estimated 1 billion people, constituting one seventh of the world's population, are affected by these NTDs. About 500,000 to 1 million deaths occur Annually because of NTDs. NTDs are chronic, disfiguring and disabling conditions. They are among the leading perpetuators of poverty as they significantly diminish economic productivity in affected adults, intellectual and physical development of the next generation, thus reinforcing a cycle of poverty.

Among these NTDs are those targeted for elimination as a public health problem and include Soil Transmitted Helminthes (STH), Schistosomiasis (SCH), Trachoma, and Lymphatic Filariasis. Those for elimination are leprosy, Human African Trypanosomiasis and Onchocerciasis.

Eswatini is not spared from the increasing burden of NTDs. In 2015, Eswatini's national prevalence of schistosomiasis among 10 to 14-year-old school children was 10.25%. To respond to this situation, the Ministry of Health (MoH) developed a national masterplan as a tool for control, elimination, and eradication of NTDs. The NTDs master plan is a product of joint efforts and intensive consultation process between health workers and experts in NTDs control and elimination. The comprehensive Eswatini multi-year plan provides the national NTDs situational analysis, with strategies that will be used to prevent, control, and eliminate NTDs in the country. This master plan is a guiding tool as to how the NTDs agenda should move ahead in Eswatini. It is a framework for partners' coordination, harmonization, and alignment.

Finally, I would like to request all health workers to make use of this NTDs masterplan and provide standardised high-quality care to all people affected by Neglected Tropical diseases.

Thank you all.

Director of Health Services

Acknowledgements

The Ministry of Health (MoH) would like to acknowledge the World Health Organization (WHO); University of Eswatini (UNESWA), Eswatini Antivenom Foundation (EAF) for the technical and financial support offered in the conception, development and finalization of the NTDs multiyear master plan

We are indebted to all the stakeholders whose tireless efforts; dedication, comments, suggestions, and contributions have tremendously helped in making this guiding document possible. Special thanks go to National NTDs Task force, NTDs specialists, medical officers, nurses, Environmental Health Officers, and dieticians for their valuable technical support received throughout the development of this NTDs master plan.

List of Contributors

NO	NAME	ORG. AND POSITION
1	Mbongiseni Mathobela	SPO- NMP/NTDS
2	Thelma Fakudze	MOH- NURSING SISTER (LOBAMBA CLINIC)
3	Chazile Mtshali	MOH-NTDS EHA
4	Londiwe Mabuza	MOH- NTDS EHA
5	Quinton Dlamini	MOH- NMP/NTDS PROGRAMME MANAGER
6	Susan Mkhonta	MOH- NTDS EHO
7	Khanyisile Nhlabatsi	MOH- NTDS EHO
8	Jesca Chokani	WHO- SID OFFICER
9	Makhoselive Dlamini	WHO-NMP
11	Sibonakaliso Vilakati	NMP- IT
10	Levison Nkhoma	WHO- CONSULTANT
12	Prof Nicholas Midzi	WHO- CONSULTANT

Table of Contents

Preface	i
Acknowledgements	ii
List of Contributors	i
Table of Contents	ii
List of Tables	iii
Table of figures	iv
Abbreviations and Acronyms	v
Key Definitions	vi
Executive Summary	vii
PART 1: NTD SITUATION ANALYSIS	4
Section 1.1. Re-assessment of National Priorities and the National, Regional and Glob	al NTD
Commitments	4
Section 1.2. National Context Analysis	11
1.2.1 Country analysis	11
Section 1.3. Gap Assessment	33
Section 1.4. Programme Context Analysis	36
Section 1.5: Building on NTD Programme Strengths	54
2.1. NTD Programme Mission and Vision	60
2.2: Milestones and Targets	61
Section 2.3: Guiding Principles	70
Section 2.4: Strategic Pillars and Strategic Objectives	70
2.4.1. Programme Strategic Pillars	70
2.4.2. Strategic Priorities	71
2.4.3 Programme Strategic Agenda Logic Map	73
Part 3: Implementing the Strategy: NTD Operational Framework	74
Section 3.2: Toward NTD Programme Sustainability: Intensifying Coordination and	
Partnerships	82
Annex 1 STH and SCH prevalence by Tinkhundla	105
Annex 2: NTD Endemicity Statuses and Five-year target populations by inkhundla	109
Annex 3: Eswatini NTD National Programme Organization Chart	112
Annex 4: NTD Commodities Forecasting Dashboard	113

List of Tables

Table 1: NTD Master Plan Tools	3
Table 2: Endemic NTDs in Eswatini	5
Table 3: Demographic Data	.13
Table 4: Six Health System Building Blocks	. 22
Table 5: Distribution of Health Facilities across Regions by type	.24
Table 6: Gap Assessment	. 33
Table 7: National population data, schools, and health facilities at district level	.44
Table 8: Known disease distribution in the Country (2016-2021)	.45
Table 9: NTD Co-endemicity	.46
Table 10: NTD mapping status 2015	.48
Table 11: Vectors and Associated NTDs	.49
Table 12: Summary of intervention information on existing NTD programmes	. 53
Table 13: SWOT analysis	. 54
Table 14: Gaps and priorities	. 58
Table 15: Vision, Mission, and goals of the NTD Programme of Eswatini	.60
Table 16: Disease-Specific Targets	. 62
Table 17: Schistosomiasis Elimination Milestones	.65
Table 18: STH Elimination Milestones	.65
Table 19: Milestones for LF elimination	.66
Table 20: Trachoma Elimination Milestones	.67
Table 21: Leprosy Control/Elimination Milestones	.67
Table 22: Milestones for Scabies	. 69
Table 23: PHASE Milestones	. 69
Table 24: Guiding principles	.70
Table 25: Strategic Priorities for the Elimination of Neglected Tropical Diseases in Eswatin	i,
2023 to 2027	.71
Table 26: Strategic Pillar 1 - Accelerating programmatic action	. 75
Table 27: Partnership Matrix	.85
Table 28: Risk Criteria and Assessment	. 87
Table 29: Steps to mitigate risks	. 89
Table 30: Performance Indicators for Pillar1: Accelerating programmatic action	. 89
Table 31: Five-year cost projections by Strategic Priorities	.95
Table 32: Five-year cost projections by Sub Activities	.97

Table of figures

Figure 1: NTD Master Plan Key Contents	2
Figure 2: NTD Master Plan and Management cycles	2
Figure 3: Economic Growth Rates	17
Figure 4: Eswatini National population pyramid (source: Census Eswatini 2023)	
Figure 5: The PEST analysis	
Figure 6: MEASURE Evaluation's Work to Support a More Unified Health Information	System
in Eswatini	27
Figure 7: Eswatini Budget expenditure 2014-2019	
Figure 8: SCH Prevalence by Tinkhundla (constituency/ district) 2015	
Figure 9: STH Prevalence by Tinkhundla (2015)	40
Figure 10: Scabies from 2020-2022 (HMIS)	42
Figure 11: Hierarchy of Objectives for national NTD programmes	60
Figure 12: Cross-cutting targets	61
Figure 13: Programme Strategic Pillars	70
Figure 14: Programme Strategic Agenda Logic Map	73

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 behavior 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 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 disease that adversely affect the health of individuals. Evidence of morbidity may be overt (such as the presence of blood in the urine, anemia, 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 lead to report directly to top level management and this again has been achieved hence the spin offs and afore mentioned achievements mentioned herein above. The third one talks about the integration of STHs into ANC and immunization programs and this again has also been achieved as evidenced by the availability of Albernazole 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 documents 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 in order to address existing cross cutting approaches and how to intensify them in a bid to eliminate NTDs as well as creating country ownership through coordination and inter-sectoral collaborations so as to ensure achievement of the desired results.

This document shall be therefore be used as a vehicle for state in planning for the country's fight against NTDs and further coordinate and strengthen partner support towards achievement of the intended objectives. It further outlines the targets for the year 2027, 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 -2023 and the globally renowned sustainable development goals. The document also fortifies the need for the integration of the NTDs into the national health care system and their inclusion and visibility in the national health development plans.

The master plan encompasses four critical sections; viz; the situational analysis in the country which also covers the national environmental contextual factors that pivotal in having a 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, 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 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 have due to their transmission dynamics 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.

It is the country's desire to ensure that for those requiring chemotherapy, at least 75% 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 on the national health strategies and or plans.

Introduction

This is comprehensive five-year Eswatini Neglected Tropical Diseases (NTD) Master Plan 2023-2027 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 NTD Master plan will also form the basis for harmonized implementation and performance monitoring of all NTD interventions.

The NTD Master Plan 2023-2027 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'. Its aim is to be a tool to plan for all relevant NTD programmes in Eritrea and facilitate alignment among partners and stakeholders for a 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 2019-2023, 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 and 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 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

<i>I uble 1. INID Musler I will I bols</i>	Table 1:	NTD	Master	Plan	Tools
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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 helminthes such as Soil Transmitted Helminthes (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 perpetuators of poverty as they significantly diminish economic productivity in affected adults and 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 has 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 wellbeing for all at 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 as a consequence. 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: 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 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 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 them 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 health care 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 reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment.

Reinforcing trust in Public Health Care System:

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

Align the growth of private health care sector with public health goals:

Influence the operation and growth of the private health care 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 private health care 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 nation-wide 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 multisectoral 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 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 that expansion of activities to prevent and control neglected tropical diseases will need adequately resourced national programmes functioning within effective health, education and other sectors in order 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 for dengue, Chagas disease, human rabies of canine origin and leishmaniasis), and their morbidity, mortality and associated stigmatization urged member states to:

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 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 in a sustainable manner 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 diseases control programmes into primary health care services and vaccination campaigns, or into existing programmes where feasible, in order to achieve greater coverage and reduce operational costs;

ensuring appropriate programme 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 and, 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 the pharmaceutical companies, donors, endemic countries and nongovernmental 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 improves 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 contribute 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 (2023-2027) 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 2027 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 2019-2023, 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 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**: which 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 km² 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 landscape, 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: national government and the local government. Figure 3.1 shows the four regions that constitute the main geographical regions of the Kingdom.



Figure 4: 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 3: 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° S and 28° S and longitude 31° E and 32° E, spanning approximately 17,364 km². 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° C, the Middleveld ranges from 400m to 800m with annual average temperatures of 20° C, the Lowveld ranges from 200m to 400m with annual average temperatures of 22° C, and the Lubombo Plateau ranges from 250m to 600m with annual average temperatures of 21° 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 April 1986. Both the country's political and legal system 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 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 stimulate community development at 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 region development and facilitate promote service delivery at Tinkhundla and Chiefdoms levels. Tinkhundla are the foundation for the bottom-up development planning process and the delivery of local services in partnership with central government. A major area of focus in the process is the 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.

Economic:

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 middleincome countries is used (World Bank, 2021). The COVID19 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 2023, 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: 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 belief in ancestors and traditional healers influences the attitudes and health seeking behaviors of the populace. These practices can prove problematic for conditions that requires 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 finding of the 2017 Population and Housing Census which was conducted in September 2017.

Population Size

The estimated population projections of Eswatini from 2022 is 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.



National Population Pyramid 2023

Figure 4: Eswatini National population pyramid (source: Census Eswatini 2023)

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, AIDI index on ICT stands at a low 18.32.

On the other hand, through the ministry of health e-health strategy which 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 influence adoption of recent technologies which include health concept as well 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. Logistics management information system (LMIS) is an organized system for collecting, processing, reporting, and using health products 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 most 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).

Political

Political or politically motivated factors that could affect the implementation of NTDs.

Government policy, political stability or instability, bureaucracy etc.

<u>S</u>ocial

Social aspects, attitudes, and trends that influence NTD Programme.

Attitudes and shared beliefs about a range of factors including health.

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

Economic

Overall economic forces that could affect the NTD Programme.

Economic trends, growth rates, taxation, inflation, interest rates, international exchange rates, international trade, labour costs, etc

Technological

Technology that can affect the way you make, distribute, and communicate NTD services.

Technology and communications infrastructure, access to technology, emerging technologies, automation, legislation around technology, research, and innovation, etc.

Figure 5: 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 of life 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 4: Six Health System Building Blocks

Service	PROFILE OF HEALTH SERVICES
delivery	The country's health care system consists of the formal and the 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).
	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 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 derivery of services at the National Referral Hospitals.

• **Community**: This level is the foundation of service delivery. 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 they 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 include 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 5: Distribution of Health Facilities across Regions by type										
	Hhohho		Lubombo		Manzini		Shiselweni		Total	
racinty Type	#	%	#	%	#	%	#	%	#	%
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%

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 referral. 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 referral psychiatric 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 about 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 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 schemes of service 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
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	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 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 client 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, which 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 wait 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 the 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 6: 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, at 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 product, 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 for 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 2023. Initially this will be conducted for TB, HIV and malaria commodities with NTDs and

these systems is funded through global fund whose focus is on malaria, TB and HI	V
in the country	
The Central Medical Store (CMS) is the national warehouse for health product	s,
vaccines and technologies. This facility is currently undergoing restructuring toward	ls
greater efficiencies and optimization of the limited space available. Distribution	of
health products is currently done from the national warehouse directly to facility	es
according to a predetermined schedule. The MOH established the Procurement Ur	it
to lead the procurement functions for all health goods and services. The unit work	76
with the accumment Tender Deard in the Ministry of Finance	19
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, the	re
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 progra	m
with the medicines control authority to the extent that there is no existing	ıg
comprehensive pharmacovigilance system and existing opportunities for information	m
exchange and incorporating the activities and processes of the pharmacovigiland	e
system into NTD programming.	1
Health National health policies typically focus on improving the population's health and	1
financing preventing diseases and health hazards so that their entire population can aspire to	1
healthy and happy life and thus productively contributing to the prosperou	5
development of the country and its economy. The achievement of national healt	1
objectives is eventually achieved through the selection of an adequate and efficient	t
combination of method of financing, organizational delivery structure for health	1
services and payment approach for health providers. In addition, other structura	1
elements contribute to the achievement of health objectives, such as the regulator	y
framework and programmes of public education. The approaches to mobiliz	Э
resources typically include a mixture of general taxation and contributions to publi	с
health systems and private health insurance schemes. The main methods of financing	3
for health care include the national health insurance system, general revenue, privat	3
insurance, community-based insurance and out-of-pocket payments. The choice of	f
method will impact on who bears the financial burden, the amount of resource	s
available and who manages the allocation of resources (Douin A. 2008).	
Health financing is a core function of health systems that can enable progress toward	s
universal health coverage by improving effective service coverage and financia	1
protection. Today, millions of people do not access services due to the cost. Man	v
others receive poor quality of services even when they pay out-of-pocket. Carefull	V
designed and implemented health financing policies can help to address these issues	
For example, contracting and payment arrangements can incentivize car	e



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.
Are there reforms to the health system or parts of it being carried out in your country?
Currently there are no reforms that are conducted in the country.
Are existing conditions of health reforms and Primary Health Care (PHC) supportive
of NID control activities even if they are not a national priority?
supportive of NTD control activities
\Box Is there a national policy on NTD control or an institutional framework for NTD
control?
With the exceptions of a National NTD master plan that is being reviewed and
updated now. There has not been any national policy on NTD control.
\Box Are NTDs included in the health sector strategic plan and the sub-national health
work plans?
The existence of health workers dedicated for NTD control, and the successful
implementation of government coordinated MIDA rounds in Eswatini over the
although there has not been specific funding allocation for NTDs control from the
fiscus.
\Box Is there a national coordinating body overseeing all control programmes or are
coordinating bodies constituted for specific programmes? N/A
□ Do constraints exist to the leadership and governance systems in the control of
NTDs?
Currently the NTD programme is under the Malaria control programme. There
is no special unit dedicated for the NTD programme coordination. This shows an
existing gap in the leadership in the control of N I Ds.
analysis and reporting of serious adverse events (SAFs)?
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.
What level of communication and cooperation exist between NTD control activities
and this pharmacovigliance unit? Are stall within this unit aware of when and where mass drug administration is planned, and do they participate in investigation and
reporting of SAEs?
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 do, they have not been fully participating
ĺ	in investigation and reporting of SAEs.
	\Box What other ministries (e.g. agriculture, local government etc.) or government
S	ectors, universities and other national research institutions are involved in health care
i	n general and NTD control in particular?
	The NTD programme has not been that visible to the extent of mobilizing for
	multi-stakeholders' collaboration, however, it is notable that there has been
	recognition of university of Eswatini during implementation of mapping of some
	key NTDs such as schistosomiasis and soil transmitted helminthiasis in the
	country.
	Does collaboration exist between the ministry of health and these sectors? For the
1	ministry of education, are there health activities in the school programmes in general
6	and specifically for the control of schistosomiasis and soil-transmitted helminthiasis
	What information exists on the inclusion of NTD control in the primary school
	curriculum?
,	The major school-based activity on NTDs has been the annual rounds of school-
1	based mass drug administration for schistosomiasis and soil transmitted
	helminthiasis targeting school age children. There is no information existing on
1	the inclusion of NTD control in the primary school curriculum.
	\Box For the Department of veterinary services, provide details on on-going
	activities/programmes relating to zoonotic diseases of public health significance in the
	country (rabies plague animal trypanosomiasis)
,	The Denartment of veterinary services has been conducting vaccination anti-
	rabies campaigns in the country All cases of hites have been considered as
	suspected realies eases were noting quick version and treatment of effected
	suspected radies cases warranting quick vaccination and treatment of affected
	cases. This exercise has maintained the level of radies in the country at a very low
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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.

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

Table 6: Gap Assessment

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	There is no appropriate country governance and commitment for NTD programme management and effective delivery.					
	implementation	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 16 of the 20 NTDs. Categorized as follows: those targeted for elimination (interruption of transmission) are two (2); targeted for elimination as a public health importance are seven (8); and those targeted for control are eight (8).

1.4.1. Current NTD Programme Organization and Status

Schistosomiasis

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.

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 NTD s 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

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 for males than females. The age distribution of Schistosoma haematobium showed that children were exposed at an early age (28% of the 4-5 years old were found positive). The peak prevalence was found in the 14-15-year-old group (41%). In the adults, the rate declined to 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 having 28% prevalence. The peak prevalence was found in the 18-19-year-old (47%). In the adults, the infection rates remain relatively high at 18%. The distribution of Schistosoma mansoni was generally confined to the Lowveld with the northern Lowveld at 30.9%, the central Lowveld at 12.9%, and the southern Lowveld at 15.6%. 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 an 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 at 14.6% than among schoolchildren in the Hhohho region at 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 that in children from schoolchildren 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 low veld, showed that Eswatini overall prevalence was 6.1% (mean age \pm standard deviation: 20.5 \pm 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 estimated at 25% in 1986, with little change over the last several decades, 25.6% in 2003, 26.5% in 2010 and 22.6% in 2012 (Utroska *et al.*, 1989; Chitsulo *et al.*, 2000; Rollinson *et al.*, 2013). The last nationwide survey of schistosomiasis was conducted and reported by each Inkhundla (administrative areas) in 2015. High risk of schistosomiasis was reported at some Tinkhundla, 30.9%, 30.1%, 29.4%, 25%, 20.4%, etc. (Fig. 4.3)



Figure 8: SCH Prevalence by Tinkhundla (constituency/ district) 2015

Soil-Transmitted Helminth

Epidemiology and disease burden

A survey was done in 2002 aimed to measure the magnitude of helminth infection amongst 0-59months children in 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 examined through the concentration technique using formalin - ether.

There has been a lot of investments made in improving coverage 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).

A national schistosomiasis survey was conducted in 2015 with the aim of estimating the prevalence of soil-transmitted helminthes (STHs) at each Inkhundla level. High prevalence rates of 24.6% and 23.0% were reported in two Tinkhundla, both located in the Highveld. A majority of the Tinkhundla areas in the country had significant endemicity of STH. Evidence of infection was not found in only three Tinkhundla (Fig.



Figure 9: STH Prevalence by Tinkhundla (2015)

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 such 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 evidence has been generated to confirm that these conditions are due to lymphatic filariasis.

Leprosy

Gaps and priorities for Leprosy:

The prevalence of the disease is not known, and data is received through HMIS. The ministry has not yet measured leprosy's prevalence rate, but it existed in the country. There is very limited effort on the control of the disease including health promotion, treatment, and surveillance activities. The main challenges are lack of trained personnel, lack of funding and weak surveillance systems. An isolated report of a single case was received in the past few years, otherwise reports of confirmed cases of leprosy are almost absent in Eswatini.

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 on the possibility of enrolling these patients on the disability grant.

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

Scabies

The cases of scabies in Eswatini has increased since year 2022. Around 8536 cases of scabies countrywide from January to September 2022 were reported. 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 4.5 illustrates the trends of scabies from 2020 to 2022.



Figure 10: 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 mortality and morbidity (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 (Padidar *et al*). 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, representative of the population. Snakes typically become active from spring in Eswatini, and most patients are bitten during the summer months. Patients report to be bitten throughout the 24-hour period, with a peak in bite incidence reported in the evenings (Padidar *et al*).

Fatalities reported to health facilities and the Eswatini Antivenom Foundation range from 10-20 per year, with a drop of 75% in fatality 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 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 as largely underestimated. Community-based surveys, public education, and 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 Ministry of Health to meeting the global goals of halving snakebite morbidity and mortality by 50% by 2030.

Region	Number	Nu	No. of	Total	Under-	5–14	Adults	No. of peripheral health facilities						
	of Admin	mb	villages or	populati	5 (Pre-	years								
	A 2	er	communiti	on	school)	(School								
		IUs	es*			age)								
								National	Regional	Health	Clinics			
								Referral	Referral	Centres				
Hhohho		15	-	356412	24949	86605	231666	1	2	2	79			
Lubombo		11	-	238910	16723	58054	155292	1	1	1	46			
Manzini		18	-	409388	28655	99478	266105	2	2	0	98			
Shiselweni		15	-	232854	16299	56583	151355	0	1	2	41			

Table 7: National population data, schools, and health facilities at district level

	No.	Nur	Number of endemic constituencies									
Region	Constituencies											
		LF	Rabies	SC	ST	Lepros	SBE	FΤ	Taenia	TRA	Scabie	
				Н	Н	у			sis		S	
Hhohho	15	*	*	15	15	*	15	*	*	*	15	
Lubombo	11	*	*	11	11	*	11	*	*	*	11	
Manzini	18	*	*	18	18	*	18	*	*	*	18	
Shiselweni	15	*	*	15	15	*	15	*	*	*	15	
Total	59	*	*	59	59	*	59	*	*	*	59	

Table 8: Known disease distribution in the Country (2016-2021)

Key:

* = unmapped

Table 9: NTD Co-endemicity

REGION	INKHUNDLA	SCH	STH	SBE	RABIES	SCAB	LF	FBT	TRA	LEP	TAE
ННОННО	Madlangempisi	✓	\checkmark	✓		\checkmark					
	Mhlangatane	\checkmark	\checkmark	✓		\checkmark					
	Mayiwane	\checkmark	✓	✓		\checkmark					
	Ndzingeni	\checkmark	✓	✓		\checkmark					
	Timphisini	\checkmark	✓	✓		\checkmark					
	Ntfonjeni	\checkmark	✓	✓		\checkmark					
	Piggs Peak	\checkmark	✓	✓		\checkmark					
	Nkhaba	\checkmark	✓	✓		\checkmark					
	Motjane	\checkmark	✓	✓		\checkmark					
	Maphalaleni	\checkmark	✓	✓		\checkmark					
	Hhukwini	\checkmark	✓	✓		\checkmark					
	Siphocosini	✓	✓	✓		\checkmark					
	Mbabane East	\checkmark	\checkmark	\checkmark		✓					
	Mbabane west	\checkmark	\checkmark	\checkmark		✓					

	<mark>Lobamba</mark>	 ✓ 	 ✓ 	 ✓ 	 ✓ 			
<mark>Manzini</mark>	Kukhanyeni	 ✓ 	 ✓ 	 ✓ 	 ✓ 			
	Kwaluseni	 ✓ 	 ✓ 	 ✓ 	 ✓ 			
	<mark>Lamgabhi</mark>	 ✓ 	 ✓ 	✓	 ✓ 			
	<mark>Lobamba</mark>	 ✓ 	 ✓ 	✓	 ✓ 			
	<mark>lomdzala</mark>							
	Ludzeludze	✓	✓	✓	 ✓ 			
	Nhlambeni	✓	✓	✓	 ✓ 			
	Mangcongco	✓	✓	✓	 ✓ 			
	<mark>Mafutseni</mark>	✓	✓	✓	 ✓ 			
	<mark>Mahlangatsha</mark>	✓	✓	✓	 ✓ 			
	Mtfongwaneni	✓	✓	✓	 ✓ 			
	<mark>Mkhiweni</mark>	✓	✓	✓	 ✓ 			
	<mark>Manzini north</mark>	✓	✓	✓	 ✓ 			
	Manzini south	 ✓ 	 ✓ 	✓	✓			
	Phondo	 ✓ 	 ✓ 	✓	✓			
	Ntondozi	 ✓ 	 ✓ 	✓	 ✓ 			
	Ngwemphisi	✓	✓	✓	 ✓ 			
	<mark>Nkomiyahlaba</mark>	✓	✓	✓	 ✓ 			
Lubombo	Lugongolweni	✓	✓	✓	 ✓ 			
	Mpolonjeni	✓	✓	✓	 ✓ 			
	Mhlume	✓	✓	✓	 ✓ 			
	<mark>Gilgal</mark>	✓	✓	✓	 ✓ 			
	Dvokodvweni	 ✓ 	 ✓ 	✓	 ✓ 			
	<mark>Matsanjeni N.</mark>	 ✓ 	 ✓ 	 ✓ 	 ✓ 			
	<mark>Lomahasha</mark>	✓	✓	✓	 ✓ 			
	<mark>Nkilongo</mark>	✓	✓	✓	 ✓ 			
	<mark>Siphofaneni</mark>	 ✓ 	 ✓ 	 ✓ 	 ✓ 			
	Sithobela	✓	✓	 ✓ 	 ✓ 			
	Lubuli	✓	✓	✓	 ✓ 			
<mark>Shiselweni</mark>	Hosea	✓	✓	✓	<mark>√</mark>			
	Gege	 ✓ 	 ✓ 	✓	<mark>√</mark>			
	<mark>Mtsambama</mark>	 ✓ 	 ✓ 	✓	<mark>√</mark>			
	Sandleni	 ✓ 	 ✓ 	 ✓ 	 ✓ 			
	Khubutha	 ✓ 	 ✓ 	 ✓ 	<mark>√</mark>			
	Nkwene	✓	✓	✓	<mark>√</mark>			
	Ngudzeni	 ✓ 	 ✓ 	✓	 ✓ 			
	Maseyisini	 ✓ 	 ✓ 	 ✓ 	 ✓ 			
	Shiselweni 1	 ✓ 	 ✓ 	✓	 ✓ 			
	Shiselweni 2	 ✓ 	 ✓ 	✓	 ✓ 			
	Zombodze	 ✓ 	 ✓ 	✓	 ✓ 			
	Somntongo	✓	✓	✓	✓			

Sigwe	 ✓ 	✓	 ✓ 	
<mark>Methula</mark>	 ✓ 	 ✓ 	 ✓ 	
Matsanjeni S.	 ✓ 	 ✓ 	 ✓ 	

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 on-going NTD control programmes. The information should be organized into the following sections:

a) <u>Completeness of the mapping and survey need.</u>

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 base line 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, STH. Although the health facility reports show that snakebite envenoming, and scabies have been documented in all tinkhundla, there is still 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 endemnicity. Table 5 describes in detail completeness of the mapping and survey needs.

Endemic NTD	Total # Tinkhundla	No. of endemic Tinkhundla	No. of Tinkhundla mapped or known endemicity status	No. of Tinkhundlaremainingtobemappedassessedforendemicity status
Schistosomiasis	59	59	59	0
Soil-Transmitted	59	59	59	0
Helminthiasis				
Trachoma	59	-	-	59
Rabies	59	-	-	59
Snakebites	59	59	-	59
Leprosy	<mark>59</mark>	-	-	
Lymphatic filariasis	59	-	-	59
Foodborne	59	-	-	59
Trematodiasis				
Scabies	59	59	59	0
Taeniasis	59	-	-	59

Table 10: NTD mapping status 2015

Key: - = Not yet mapped.

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

Vector control: Integrated Vector Management (IVM)

LF, SCH and malaria are targeted for vector control in Eswatini basing on their life cycles. The integrated vector management (IVM) approach is implemented in the country with 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 disease. 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 was 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 transmitting, treatment of breeding sites for both malaria mosquito vectors and SCH intermediate host snails become 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.

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

IVM for Vector borne diseases including NTDs in Eswatini

Table 11: Vectors and Associated NTDs

One-Health

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

WASH

Proportion of population using 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% for the rural population had access according to Swaziland Human Development Report, in 2000. More recent reports show that the rural access to safe water had 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 household's use of improved sources for drinking water.

There has been a drastic decline in the sanitation coverage both in urban and rural area in 2014. The reason is that there has been a revision of the definition for 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 a sustainable and quality health and nutrition interventions across the education sector, and strengthening coordination, linkage and partnership with relevant ministries, communities and other stakeholders. MDA is also conducted for school age children at school level with the involvement of the school community.

NTDs and Gender and Equity

Bases on the exposure status some of the NTDs are more prevalent to specific gender group. Some of the NTDs are more prevalent in women and to worsen the matter the health seeking behaviour (affected by level of educational, 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), promoting equality with regard to 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, 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).

NTD	Date progra mme started	Total Districts targeted	No. districts covered (geographi cal coverage*)	Total populati on in target district	No. (%) Cove red	No.(%)districtswithrequirednumberofeffectivetreatmentrounds	No. (%) districts that have stopped MDA	Key strateg ies used	Key partners
LF	0	59	0	-	0	-	-	Vector Control	
Foodborne Trematodiasis	0	59	-						
SCH	2016	59	59 (100)	1 200 000		59 100)	59 (100)	MDA	
STH	2016	59	59 (100)	1 200 000		59 (100)	59 (100)	MDA	WHO, UNICEF, CHAI
TRA		59	-						
SBE	2021	59	59 (100)	1 200 000		59 (100)	59 (100)	Case manag ement	Eswatini Antivenom Foundation
Taeniasis		59	-						
Scabies		59	59 (100)	1 200 000		NA	NA		
Rabies		59	-						
Leprosy		<mark>59</mark>	1(1.7)						

Table 12: Summary of intervention information on existing NTD programmes

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

Fable 13: SWOT analysis					
Strengths	Weaknesses				
1. Existence of a skeletal mass of HR	1. Lack of professional disciplines in				
with institutional memory of NTD	the NTD Program.				
program	2. Inadequately defined structure of				
2. Availability of drugs.	NTDs management.				
3. Availability of partners to support in	3. Lack of knowledge and skills among				
implementation of NTD activities.	healthcare workers and stakeholders				
4. The availability of the program	regarding NTDs.				
management (Chief E.H.O and	4. Lack of resources to draft and				
Program manager)	establish guidelines to address all the				
5. The existence of malaria vector	NIDs and NID pharmacovigilance				
control and integration of the malaria	1ssues.				
The clobal action to integrate NTDs	5. There is no clear organogram and				
6. The global action to integrate NTDs.	asks are not well defined.				
Commitment from national government	the elimination of NTDs				
7 Partially established NTD	7 Inadequate research no independent				
nrogramme though not well defined	pre-and-nost MDA coverage survey				
8 The country has experience in	and impact measurement.				
tackling NTDs.	8. 8. Nonexistence of vector control				
9. Have eliminated leprosy as a public	bevond malaria				
health problem (reduction of the	9. Inadequate government leadership of				
prevalence rate to less than one case	national NTD agenda				
per 10 000 populations) at national	10. The gap in financial and other				
level	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		
 Existence of School health programme jointly run by Ministry of Education and Ministry of Health. Existence of the Nutrition Council which is coordinating nutrition activities in the country. 	 High donor dependency Dependency on external resources for surveillance, monitoring and evaluation. Inadequate resources for implementation. 		
 Support from the partners to conduct trainings and draft guidelines. 	4. Drug donations are for selected groups, yet prevalence is across all ages.		
 4. Increased partnership and collaboration 5. Integration/Co-implementation (e.g) 	 Climate change No budget line for NTDs within MoH. 		
IVM) 6. Increasing momentum to tackle NTDs.	 7. Competing priorities in the health sector 8. Complex emergencies a g COVID 		
7. The existence of the 2021-2030 NTD Road Map	19 pandemic		
8. International investments in 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 a health and and tools including a health and and tools including a health and a			
time information technologies			

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 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.

Weakness

Weak coordination of many national NTD programmes and inadequate government leadership of 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, soiltransmitted 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 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. 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 14: Gaps and priorities

Gaps	Priorities		
NTDs are not part of National Priorities	Mainstream NTD into the National Health System and advocate for budget allocation		
Limited professional disciplines in the NTD Program	Identify human resources and build capacity on NTD program activities.		
Lack of pharmacovigilance for NTDs	Capacity of the health workers on adverse events (AEs) related to NTDs treatment.		
	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 commitment from all relevant stakeholders to advocate for the elimination of NTDs.	Advocacy Enhance NTD monitoring and evaluation, surveillance and operational research.		
Lack of research, no independent pre- and-post MDA coverage survey and impact measurement.	Provide financial resources for research, monitoring and evaluation of the NTD programme.		
Planning for NTD specific disease interventions is still done in silos	Integrated planning		
WASH and NTDs programme are not integrated.	Strengthen coordination and collaboration.		
	Strengthen inter-sectoral collaboration		

Gaps	Priorities		
Lack of harmonized programme policies and interventions			
Partners interested in supporting NTD activities are few in Eswatini	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	Improve data management		

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 11: Hierarchy of Objectives for national NTD programmes

2.1. NTD Programme Mission and Vision

Table 15: 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 2025 and milestones for 2023 and 2027 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 overall national programme-



Figure 12: Cross-cutting targets
Table 16: Disease-Specific Targets

National target	Diseases	Objective	Year	Strategies	
Targetedforelimination(transmissioninterruption)(transmission)	Leprosy	Number of Tinkhundla with zero autochthonous leprosy	2027	Sustained active case finding & single dose rifampicin f	or contacts
Targeted for elimination as a	Schistosomiasis	Achieve <1% proportion of heavy intensity of SCH infection	2027	Mass drug administration, WASH improvement, public health education, snail control	
public health problem	Soil-transmitted helminths	Achieve <2%proportion of STH infection of moderate and heavy intensity	2027	Health Education MDA Case management Surveillance WASH	
	Lymphatic filariasis	To be validated for elimination of LF as a public health problem	2027	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	2027	WASH Health Education Case management MDA Surveillance	

National target	Diseases	Objective	Year	Strategies
		trachomatous		
		inflammation—follicular in		
		children aged 1–9 years of		
		<5% in each formerly		
		endemic district; and (iii)		
		written evidence that the		
		health system is able to		
		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	2027	Post-exposure prophylaxis, dog vaccinations, morbidity
		deaths from rabies		management
	Scabies	Incorporated scabies	2027	Mass drug administration
Targeted for		management in UHC		IDM
control		package		
	Snakebite	Achieve reduction of	2027	Provision of antivenom to all health facilities, morbidity
	envenoming	mortality by 50%		management, public health education for early treatment
				seeking
	Taeniasis and	To increase to 100% the	2027	MDA, Health Education, Case management, Surveillance
	Cysticercosis	number of endemic		Vaccination/treatment of pigs (one health concept)
	-	Tinkhundla with		
		Intensified control		

National target	Diseases	Objective	Year	Strategies
	Foodborne	Number of of endemic	2027	Implementing preventive chemotherapy (MDA), Health
	trematodes	Tinkhundla with		Education, Case management, Surveillance
		intensified control		

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 17: Schistosomiasis Elimination Milestones

Indicators	2023	2024	2025	2026	2027
Achieved 100% geographical coverage for MDA	59	59	59	59	59
in SCH endemic tinkhundla	(100%)	(100%)	(100%)	(100%)	(100%)
Number of tinkhundla that have conducted 3-5		59	59	59	59
years of consecutive treatments with population		(100%)	(100%)	(100%)	(100%)
coverage more than 75%					
Conducted annual sentinel sites survey in at least		24	24	24	24
100% of selected sites of SCH endemic tinkhundla.		(100%)	(100%)	(100%)	(100%)
		Revisit			
Achieved 100% geographical coverage for MD in SCH endemic tinkhundla Number of tinkhundla that have conducted 3- years of consecutive treatments with populatic coverage more than 75% Conducted annual sentinel sites survey in at lea 100% of selected sites of SCH endemic tinkhundl Impact assessment survey for schistosomias conducted after 5 years of successive annual MD Endemic tinkhundla achieved elimination as public health problem		this with			50
applied assessment survey for sensiosonnasis		the			(100%)
conducted after 5 years of successive annual MDA		guidance			(100%)
		of chip			
Endemic tinkhundla achieved elimination as a		27	27	44	59
public health problem		(46%)	(46%)	(75%)	(100%)

Table 18: STH Elimination Milestones

Indicators	2023	2024	2025	2026	2027
Achieved 100% geographical coverage for	59	59	59	59	50 (100%)
MDA in SCH endemic tinkhundla	(100%)	(100%)	(100%)	(100%)	39 (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 SCH endemic tinkhundla.		24 (100%)		24 (100%)	24 (100%)
Conducted impact assessment survey (integrated in schistosomiasis surveys) in 100% of STH endemic tinkhundla	Revisit this with guidance of chip				59 (100%)
Endemic tinkhundla achieved elimination as a public health problem		27 (46%)	30 (50%)	44 (75%)	59 (100%)

Table 19: Milestones for LF elimination

Indicators	2023	2024	2025	2026	2027
1. Completed mapping of LF and determined LF endemic areas and the population at risk		59 (100%)			
in all Tinkhundla in Eswatini			1000/	1000/	1000/
requiring LF MDA	100%	100%	100%	100%	100%
3. Geographical coverage of LF MDAs in endemic Tinkhundla	100%	100%	100%	100%	100%
2. Number of IUs conducted 5 rounds of MDA with coverage more than 65%					100%
3. Number of IUs conducted first TAS activities after at least 5 rounds of MDA among those declared endemic.					100%
4. Number of IUs conducted and passed at least 2 TAS activities.		<mark>100</mark>	<mark>100</mark>	<mark>100</mark>	<mark>100</mark>
7. Started passive surveillance & vector control activities in at least 100% of Tinkhundla					100%
8. Prepare and present "the dossier" for in country validation of absence of LF transmission					1 (100%)
9. Proportion and number of Tinkhundla where there is full coverage of morbidity- management services and access to basic care	15%	50%	75%	100%	100%
Proportion and number of IUs where 75% of hydrocele cases benefitted from appropriate surgery		15%	50%	75%	100%

Table 20: Trachoma Elimination Milestones

Indicators	2023	2024	2025	2026	2027
Completed mapping of trachoma	59 (100%)				
Achieved 100% MDA geographical coverage in Trachoma target tinkhundla	(100%)	(100%)	(100%)	(100%)	(100%)
Conducted the prevalence based required number of MDA achieving at least 80% of epidemiological coverage in endemic tinkhundla	(100%)	(100%)	(100%)	(100%)	(100%)
Conducted impact assessment activities in at least 100% of Trachoma target tinkhundla after the stipulated number of cycles based on prevalence			(100%)	(100%)	(100%)
Prepare and present "dossier" for in country validation for elimination as a public health problem				X (50%)	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					X (100%)

Table 21: Leprosy Control/Elimination Milestones

Indicators	2023	2024	2025	2026	2027
Leprosy					
Achieved active case detection of	50 (100%)	59	59	59	59
leprosy in all endemic tinkhundla	39 (100%)	(100%)	(100%)	(100%)	(100%)
Achieved passive case detection of	59 (100%)	59	59	59	59
leprosy in 100% of all tinkhundla		(100%)	(100%)	(100%)	(100%)
Managed all leprosy patients in	50 (100%)	59	59	59	59
peripheral health facilities	59 (100%)	(100%)	(100%)	(100%)	(100%)
Achieved 100% treatment coverage of	59 (100%)	59	59	59	59
identifies leprosy cases		(100%)	(100%)	(100%)	(100%)

Indicators	2023	2024	2025	2026	2027
Prepared and present "dossier" for in country verification for elimination of leprosy (elimination of transmission)					59 (100%)
Achieved elimination of leprosy transmission					59 (100%)

Rabies					
1. Ensure timely access to post-exposure	59 (100%)	59	59	59	59
prophylaxis rabies vaccine		(100%)	(100%)	(100%)	(100%)
2.Availability of post-exposure	50 (100%)	59	59	59	59
prophylaxis in health facilities	39 (100%)	(100%)	(100%)	(100%)	(100%)
3. Mass dog vaccination for rabies for at	50 (100%)	59	59	59	59
least 70% of dogs	39 (100%)	(100%)	(100%)	(100%)	(100%)
4 Wound management for dog bites	59 (100%)	59	59	59	59
4. would management for dog blies		(100%)	(100%)	(100%)	(100%)
Build national capacity of health		59	59	59	59
workers for rabies exposure assessment,		(100%)	(100%)	(100%)	(100%)
diagnosis, administration of post-	50 (1000/)				
exposure prophylaxis) and for dog	39 (100%)				
management prophylaxis) and mass dog					
vaccination.					
5 Achieving zero death from rehies	50 (100%)	59	59	59	59
5. Achieving zero death from rables	59 (100%)	(100%)	(100%)	(100%)	(100%)

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

Table 22: Milestones for Scabies

Indicators	2023	2024	2025	2026	2027
Mapping to identify the burden of disease and endemic areas					
Incorporation of scabies management in the minimum package of care					
Conduct case management for all cases		100%	100%	100%	100%
Establish surveillance for scabies	25%	50%	50%	75%	100%
Established capacity for case management of scabies in all health facilities	25%	50%	75%	100%	100%

Table 23: PHASE Milestones

Indicators	2023	2024	2025	2026	2027
Proportion of tinkhundla receiving integrated MDA	30	35	40(59	59
with a coverage of at least 75%	(%)	(%)	%)	(100	(100
				%)	%)
Proportion of tinkhundla receiving appropriate health	30	35	40(59	59
education on NTDs	(%)	(%)	%)	(100	(100
				%)	%)
Proportion of endemic tinkhundla with adequate	10	30	40	50	59
access to clean water supply	(17	(51%)	(%)	(68	(100
	%)			%)	%)
Proportion of endemic tinkhundla with adequate	10	30	40	50	59
sanitation	(17	(51%)	(%)	(68	(100
	%)			%)	%)
Proportion of endemic tinkhundla with adequate	10	30	40	50	59
environmental manipulation	(17	(51%)	(%)	(68	(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 24: Guiding principles

Guiding principles	•	National leadership and ownership,
	•	Commitment to collaboration and sharing,
	•	Mutual accountability of national authorities and partners, Transparency, and accountability,
	•	Community engagement and participation
	•	Safety: 'Do no harm' while providing health benefits

Guiding Principles are a broad philosophy that encompass your personal 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 are simply the 3-5 strategic areas your programme must win to be successful. The below figures provide programme strategic pillars.



Figure 13: Programme Strategic Pillars

2.4.2. Strategic Priorities

Strategic priorities are the big-picture objectives for the programme: they describe what the programme will do to try to fulfil its mission.

Table 25: Strategic Priorities for the Elimination of Neglected Tropical Diseases in Eswatini, 2023 to 2027

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

	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	1. Strengthen country ownership and leadership at all levels and
Models and culture to	ensure allocation of domestic funding for the NTD program
facilitate country	2. Establish a functionally distinct NTD Unit with the Director who
ownership	coordinate centralized NTDs programmes and reports to higher
	authorities to improve visibility of NTDs in a similar way as other
	health programme like malaria, 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)
SP4: Strengthening	1. Advocate for domestic resource allocation
the Resource	2. Promote community involvement and ownership of the program for
Mobilization,	optimal use of available resources
Coordination and	
Inter-	3. Promote partnership and coordination NTD programme implementation
sectoral Collaboration	
IOF THE FILMINATION OF	4. Build NTD programme capacity for resource mobilization
IN I DS	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 14: 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 countries.

 Table 26: Strategic Pillar 1 - Accelerating programmatic action.

Section 3.1: Strategic priorities and Key Activities			
Strategic Priorities	Key Activities	Time frame	Resources needed
Strategicpriority1:Integratedpreventivechemotherapy to maintain100%geographic	Implement MDA for SCH in all tinkhundla (#59)	Annually (2023- 2027)	HR, Financial resources, medicines, supplies (stationary, measuring tape, etc.), vehicles
coverage, scale down PC intervention where applicable and achieve the minimum disease specific	Conduct mapping of LF and estimate population requiring interventions	2024	HR, taeniasis mapping experts, transport, financial resources, diagnostic tools
treatment coverage level for SCH, LF and STH.	Conduct MDA for LF in targeted Tinkhundla	2024 -2027	HR, Financial resources, medicines, supplies (stationary), vehicles,
	Conduct Social mobilization and BCC	2023- 2027	IEC materials (posters, leaflets, Billboard, conference cost, funding
	Conduct MDA for scabies where applicable	2023-2027	HR, Financial resources, medicines, supplies (stationary, measuring tape, etc.), vehicles
	Conduct mapping for trachoma to determine the population requiring interventions	2023	HR, trachoma mapping experts, transport, financial resources, diagnostic tools
	Conduct MDA for trachoma in endemic Tinkhundla	2024	HR, Financial resources, medicines, supplies (stationary, measuring tape, etc.), vehicles
	Conduct mapping to determine endemicity of taeniasis and to estimate population requiring intervention	2024	HR, taeniasis mapping experts, transport, financial resources, diagnostic tools
Strategic priority 2: Ensure early detection and prompt treatment of targeted case management	Strengthen Institutional capacity building for laboratory services'	2023	Conference facilities, transport, fuel, requisite HR, Reagants
NTDs	Conductburdenassessment for Scabies andRabies	2023	Funding, experts, tools, supplies, transportation,
	Build capacity of HCWs on case management, morbidity management and disability prevention	Annual	HR, funding, development of guidelines and manuals, stationery,
	Build capacity of HCWs, communities and teachers on NTDs	Annually	HR, funding, guidelines and manuals, stationery,
	Build national capacity for timely detection and	Annually	Expert, supplies (diagnostic kits, medicines), funding,

	response for outbreak prone NTDs – surveillance training Ordering medicines and diagnostic kits for CM NTDs (Annually	transportation, tools (Rapid assessment guideline, etc), stationary materials, 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)	2023	Expert, funding, commodities
	Develop guidelines and manuals for NTDs	2023 and review	Expert, funding, supplies, transportation, infrastructure,
Strategic priority 3: Prioritize and strengthen	Conduct confirmatory mapping LF		Expert,ICT,funding,transportation, tools
evaluation for tracking progress in line with the 2030 NTD Road map and	Conduct SCH impact assessment	2024, 2026	Expert, supplies, funding, transportation, IEC
SDGs	Conduct STH impact assessment	2024, 2026	Expert, supplies, funding, transportation, IEC
	Establish and monitor sentinel sites for surveillance of SCH and STH	Annually	Expert, tools, funding, transportation
	Conduct an integrated MDA surveycancelled	Annual	Coverage survey protocol, HR, transportation
	Conduct a baseline survey burden for CM NTDs	2023	Guidelines and tools, funding, transportation, kits and medicines, experts
	Prepare and submit dossier for the elimination of LF	2027	National documents and reports, experts, transportation, HR, funding, stationary materials,
	Strengthen national HMIS- Integration. of NTDs variable/ development of NTD Modules	2023	Expert, funding, IT equipment, tools/manuals,
Strategic priority Identify and prioritize operational	Expert consultation and consensus on priority research areas for NTDs (KAP, sentinel sites, uptake	Annual	Expert, funding, venue

research to facilitate NTD implementation	coverage,impactassessment,drugefficacystudies)studies)CarryoutPharmacovigilanceassessment/testingthesafety of the medicinesBuild institutional capacityto conduct researchPublishanddisseminateresearch	Annual Annual Annually	Experts, HR, Transport, funding Expert, venue, funding HR (experts, prog managers, policy maker, venue, funding, stationary
Strategic Pillar 2. Intensify	cross-cutting approaches		
StrategicPriority:Strengthenandmainstreamplatformswithsimilardeliverystrategiesand	Conduct Integrated delivery of service for NTDs and (EPI, MCH, nutrition, TB, Malaria)	Annually	Advocacy and consensus building, HR, funding, tools, transportation, medicines, kits
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	Annual	Supplies (ITN, IRS, larviciding chemical and molluscides), funding, experts, transport, IEC, guidelines
	Conduct integrated MDA for SCH, STH, LF	Annualfrom 2024 going forward	Guidelines and manuals, HR, funding, medicines, SAE reporting tool, tools, transport, IEC material
	Integrate with WASH/Environmental Health	Annual	Expert, funding, transport, IEC material,
	Capacity building on provision of integrated services (IVM Training)	2023 -2024	Expert, funding, guidelines and manuals, venue, stationery
	Monitoring and evaluation of the program activities- Develop the NTD M&E Framework	2023	Expert, funding, data collection tools, computers, phone and airtime, transport
Strategic Priority: Strengthen national supply chain management systems to ensure timely	Advocacy for wavering free importation of donated medicines and supplies	Annual	National Policy, HR
safe, and effective supply of quality assured NTD products and medicines	Strengthening capacity for the national supply chain management systems canncelled	Bi annual cancelled	Expert, funding, tools, conference facility

	Improve infrastructure- renovation of the office	2023-2027	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 trainings	Bi annaul	experts, HR, Transport, funding, (conference), Storage place, logistic management information system
StrategicPriority:Integrated NTD planning,implementation,andmonitoring	Conduct annual programme review and stakeholders' meetings	Annual	Funding, venue, transport, HR, stationery,
	Conduct Quantification, application, and procurement of supplies for CM NTDS	Annually	HR, tools, transport
	Conduct supportive supervision	Quarterly	Experts, tools, funding, transport
	Participate in international meetings	Annually	HR, Funding, conference facilities
Strategic Priority: Strengthen multi-sectoral	Strengthen coordination mechanism	Annually	HR, TORs, funding
(WASH, One Health, Ministry of Education,	Establish the NTD technical working group	2023	Funding, conference, HR, transport
Finance, Agriculture, Water and Land, etc.)	Conduct Regular planning and review meetings	Quarterly	Funding, experts, programme reports, venue, transportation
	Develop multisectoral strategic plan	2024	Experts, guidelines, tools, funding
StrategicPriority:Strengthencountryprogramownershipand	Conduct planning workshops- cancelled	Revisit	Experts, planning tool, funding (stationery, transport)
leadership at all levels	Advocate for domestic funding	Annually	Advocacy tools, experts, funding, venue, stationary, IEC materials, transportation
	Improve community involvement	Annual	IEC, community leaders, experts, funding, transport, venue
	Advocate for Gender, equity, and human rights (GER) agenda	annual	Experts, funding, venue, transport, monitoring tools
	Advocate for Inclusion of NTDs in the National	2023	HR, experts, transport

	Health Sector Strategic Plan		
	Support NTD service provision at Primary Health Care (Universal Health Care)	Quarterly	National Health Policy, HR, tools, guidelines, transport
	Advocate for Inclusion of NTD indicators in national HMIS	2023	Tools (disease specific indicators, HMIS), existing NHP, HR, experts, IT, funding
Strategic Priority: Empower local capacity for social mobilization, communication and	Create community engagement and communication	Annually	IEC materials, Experts, funding, transport
building support for NTD interventions	Build capacity for resource mobilization	Annually	Funding, transport, experts
	Promote Involvement of all community groups (swimmers, fishermen, farmers, business, etc)	Annually	Experts, funding, Autotransporter, venue, shelter structures, gazebo, promotional materials, public address system
Strategic Priority: Strengthen collaboration with other sectors (WASH,	Strengthen coordination mechanism among various sectors	Quarterly	SOP, HR, venue, stationary
Environment, Education, Community organizations)	Conduct regular programme planning and review meetings	Annually removed	HR, funding, programme report
Environment, Eaucation, Community organizations)	ConductregularprogrammeplanningandreviewmeetingsPromoteintegratedprovision	Annually removed 2024	HR, funding, programme report National strategy, HR
Environment, Eaucation, Community organizations)	ConductregularprogrammeplanningandreviewmeetingsPromoteintegratedprovisionInvolvementofcommunityinNTDinterventions	Annually removed 2024 Annual.	HR, funding, programme reportNational strategy, HRIEC, stationary, vehicle, airtime, smartphone
Environment, Education, Community organizations) Strategic Filler 4. Strengti NILLS	ConductregularprogrammeplanningandreviewmeetingsPromoteintegratedprovisionInvolvement of communityin NTDinterventionsienResourceMobilization	Annually removed 2024 Annual.	HR, funding, programme report National strategy, HR IEC, stationary, vehicle, airtime, smartphone Immunication for the elimination of
Environment, Education, Community organizations) Strategic Pilline 4. Stronger Millox Strategic Priority: Build NTD programme capacity for resource mobilization	ConductregularprogrammeplanningandreviewmeetingsPromoteintegratedprovisionInvolvement of communityin NTDinterventionsInterventionsInterventionsInterventionsInterventionsInterventionsInterventions	Annually removed 2024 Annual. Coordination and Co Annually	HR, funding, programme report National strategy, HR IEC, stationary, vehicle, airtime, smartphone munufaction for the elimination of Experts, funding, conference costs - removed
Environment, Education, Community organizations) Strategic Priority: Build NTD programme capacity for resource mobilization	ConductregularprogrammeplanningandreviewmeetingsPromoteintegratedprovisionInvolvement of communityin NTD interventionsIn ResourceMobilizationConductMappingOfpotential donors	Annually removed 2024 Annual. Coordination and Ca Annually Annually	HR, funding, programme report National strategy, HR IEC, stationary, vehicle, airtime, smartphone munication for the elimination of Experts, funding, conference costs - removed Experts, funding
Environment, Education, Community organizations) Strategic Priority: Build NTD programme capacity for resource mobilization	ConductregularprogrammeplanningandreviewmeetingsPromoteintegratedserviceprovisionInvolvement of communityInvolvement of communityin NTDinterventionsInvolvement of communityin NTDinterventionsInvolvement of communityin NTDInvolvement of communityin NTDin NTDin NTDin Resultive MobilizationConductMappingOfpotential donorsConduct NTDProgrammeReviewRestructuring ofthe programme its self	Annually removed 2024 Annual. Annual. Annually Annually Review in 2025 and end term review is 2027	HR, funding, programme report National strategy, HR IEC, stationary, vehicle, airtime, smartphone Immunication for the elimination of Experts, funding, conference costs - removed Experts, funding, conference costs HR, funding, conference costs
Environment, Education, Community organizations) Strategic Priority: Build NTD programme capacity for resource mobilization Strategic Priority: Promote partnership and accordination	ConductregularprogrammeplanningandreviewmeetingsPromoteintegratedserviceprovisionInvolvement of communityIn NTD interventionsIn NTD interventionsIn NTD interventionsConductMappingMappingofpotential donorsConduct NTD ProgrammeReviewRestructuringReviewRestructuringIdentifyNTD stakeholders(internal, external)	Annually removed 2024 Annual. Coordination and Co Annually Annually Review in 2025 and end term review is 2027 Annually	HR, funding, programme report National strategy, HR IEC, stationary, vehicle, airtime, smartphone municular for the climitation of Experts, funding, conference costs - removed Experts, funding, conference costs HR, funding, conference costs HR

programme implementation	Strengthen and promote multisectoral coordination	Quarterly	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	IEC, stationery, funding, Experts
	Conduct an advocacy for policy makers	Annually	IEC, HR, funding, conference costs
	IdentifyNTDAmbassadorsandchampions (public figuresfor advocacy on NTDs)	2024	transport, Experts, funding

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

NTD Programme Partnership and Coordination Mechanism

Fig 10. Programme coordination mechanism

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Entity	Membership	Terms of Reference
National NTD Steering Committee	e (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,	 The committee serves as an advisory body to the MoH. Monitor and evaluate the implementation of the masterplan. 3. They review implementation plan. Advocate for resource mobilisation and political a. To perform any other duties related to or incidental to NTDs elimination.
National NTD Secretariat (NTD co	ordinator, M&E, HP, EHO, EH	ILS)
Meeting frequency: Chair: Host:	NTD coordinator, M&E, HP, 1.Being a secretary to the steering committee 2.Scheduling meetings 3.Coordinating the implementation of services 4.Compiling of reports 5.To perform any other duties related to or incident elimination.	
National NTD Technical Advisory	Group (Experts)	
Meeting frequency: Chair: Host:	WHO, UNICEF, FAO, MoH, MoET, World Vision, Academia	 Advisory board to the NTD Program To advise the steering committee and the secretariat They monitor the implementation of the NTD Masterplan Mapping of potential donors and partners

		5.To perform any other duties related to or incidental to NTDs elimination
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.	

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

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

State	NTDs (List)	Veterinary (List)	WASH (List)	IVM (List)	One- Health (List)	Educatio n (List)	Malari a (List)
Eswat ini	MoH	Ministry of agriculture	World vision	МоН	MoH	МоН	WHO
Eswat ini	MoET	Environmen t	Environm ental health/Mo H	МоА	MoA	UNICE F	MoH
Eswat ini	MoA	МоН	MoET	WHO	Ministry of Works	MoET	MoA
Eswat ini	Environ ment and tourism	MoET/Univ ersity	MoNR	Eswatini Environm ental Authority	WHO	UNESW A	Touris m
Eswat ini	MoNR		WHO	UNESW A	EEA	Ministry of Tinkhun dla	UNES WA
Eswat ini	Ministry of Tinkhun dla		UNICEF		CDC/PE PFA	Correcti onal Services	
Eswat ini	WHO		ESWADE				
			Water Aid				

Table 27: Partnership Matrix

3.3: Assumptions, Risks and Mitigations

Risk is the process of examining how likely risk will arise in the implementation of NTD programme. It also involves examining how the programme outcome and objectives might change due to the impact of the risk. The impact could be in terms of schedule, quality and cost.

Risk mitigation is the process of developing options and actions to enhance opportunities and reduce threats to the programme objectives. Risk mitigation progress monitoring includes tracking identifiable risks, identifying new risks, and evaluation risk process effectiveness throughout the programme period.

Table 28: Risk Criteria and Assessment

Potential risk	Before Risk Mitig	ation		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

Lack of Funding	5	5	25	Advocacy for funding and mainstreaming	3	3	9
Weak coordination	4	4	16	Coordination mechanism	1	3	3

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

Mitigation

Managing risk means mitigating the threats or capitalizing on the opportunities that uncertainty presents to expected results. Failure to identify risks and failures to come up with risk mitigation strategies can and do kill projects. If no mitigation strategy can help, then *change* your strategy and project approach

Table 29: 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

In the table below some examples of strategic objectives, performance indicators, targets and date are provided.

 Table 30: Performance Indicators for Pillar1: Accelerating programmatic action.

Strategic Priority	Performance Indicators	Target	Date
Strategic Priority 1 : scale up integrated preventive chemotherapy to achieve 100% geographic coverage and	No. of Tinkhundla with 100% geo coverage for SCH	18 IUs	2023
treatment access to SCH and STH	No of workshops conducted on NTD's	3 workshops per region	Annually (2023- 2027)
	No of individuals treated for SCH	All individuals in endemic IUs	Annually ((2023- 2027)
	No of individuals treated for STH	All individuals in endemic IUs	Biannually

	% Of HFs providing CM NTD services	100%	Annually
	% of HFs with no stockout of supplies for case management NTD supplies	0%	Annually
	% Of outbreaks detected & managed timely	100%	Annually
Strategic Priority 2: Prioritize and strengthen monitoring and evaluation to track progress and decision making towards the 2030 goals	No. of people trained	500	Annually
	CFR due to rabies	0	Annually
	No. of Completed TAS for LF	1	2025
	No. of Impact assessment completed for SCH & STH	1	2023
	No. of Tinkhundla validated for elimination of trachoma as PHP	59	2027
	No. of targeted tinkhundla completed burden assessment for at least one CM NTD	59	2027

Strategic Priority 3: Ensure timely, safe, and effective supply chain management of quality-assured NTD Medicines and other products up to the last mile	% Of Completed and submitted JAP	100%	Annually
	No. of NTD datasets submitted for Quantification of CM NTDs	Datasets for the 10 NTDs	Annually
	% Of SAE timely reported and investigated	100%	Monthly
	% Of 100% targeted HFs received supplies in time for intervention		Monthly
Table 19b: Performance Indicators for H	Pillar2: Intensify cross-cut	ting approaches	5
Stuatoria Duiovita			
Strategic Priority	Performance Indicators	Target	Date
Strategic Priority 4 Strengthen identified platforms with similar delivery strategies and interventions ((MDAs, IVM, Morbidity management,	Performance IndicatorsNo.ofintegratedcommunityawarenessactivitiesconducted	Target36(3communityactivitiespermonth)	Date Monthly
Strategic Priority 4 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	Performance IndicatorsNo.ofintegratedcommunityawarenessactivitiesconductedNo.ofintegratedtrainingsonNTDdatamanagement	Target36(3community activities per month)1 training per year	Date Monthly Annually

Strategic Priority 5: Mainstream delivery platforms within the national health system	Prepare consolidated list of national research agenda for priority NTDs	1	Annually
	No. of studies on vector identification/control related to NTDs	1	Annually
Strategic Priority 6: Integrate safety across NTD planning, implementation, and monitoring	No. annual NTD planning and review meeting	1 workshop	Annually
	No. of annual plan submitted to ESPEN	1	Annually
	% Of NTDs managed according to Guidelines	100%	Annually

Table 19c: Performance Indicators for Pillar 3: Operating Models and culture to facilitate country ownership

Strategic Priority	Performance Indicators	Target	Date
Strategic Priority 7 : Promote and strengthen country ownership and leadership through organizational	Proportion of the national WASH coverage (full coverage)	100%	Annually
structures at national and local government with dedicated funding	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	2023, 2025, 2027

	No. of people trained on NTD involvement from other sectors (Education, WASH, etc)	200 people from the different sectors	Annually		
Strategic Priority 8: Empower local government and authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions	No. of NTD trainings conducted	36 weekly meetings	Annually		
	No. of social mobilization sessions	10 activities	Annually		
	No. of community leaders involved in MDA (at least one for each community)	200 leaders	Annually		
Table 19d: Performance Indicators for Pillar4: Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs					
Strategic Priority	Performance Indicators	Target	Date		
StrategicPriority9:Promotecommunityinvolvementandownership of the program for optimal	No. of people trained on resource mobilization	2 people for training	Annually		
use of available resources	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	1	Annually		

Strategic Priority 10: Promote improved communication and awareness at the community level for	No. of CHW participated on MDA campaign in every community	120 (2 CHW per Inkhundla)	Annually
a successful elimination of the endemic NTDs.	% 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 31: Five-year cost projections by Strategic Priorities

Activity	2023	2024	2025	2026	2027	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	2023	2024	2025	2026	2027	TOTAL
Strategic Priority 3:2 - Empower local capacity for social						
mobilization, communication and building support for NTD	270,000	281,394	293,269	305,645	318,543	1,468,851
interventions						
Strategic Priority 3:3 - Strengthen collaboration with other						
sectors (WASH, Environment, Education, Community	200,000	208,440	217,236	226,404	235,958	1,088,037
organizations)						
Strategic Pillar 4. Strengthen Resource Mobilization,						
Coordination and Communication for the elimination of	650,000	521,100	977,563	566,009	1,061,810	3,776,482
NTDs						
Strategic Priority 4:1 - Build NTD programme capacity for	0		271 545		29/ 9/7	566 / 192
resource mobilization	0	0	271,545	0	2/7,/77	500,772
Strategic Priority 4:2 - Promote partnership and coordination	200,000	208 440	217 236	226 404	235 958	1 088 037
for NTD programme implementation						1,000,007
Strategic Priority 4:3 - Advocate for domestic resource	450.000	312,660	488.781	339.605	530.905	2,121,952
allocation						2,121,222
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Inflation rate 4 22% Category: Implementation costs Operational costs						

Table 32: Five-year cost projections by Sub Activities

Sub-activity	2023	2024	2025	2026	2027	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													
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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 platform	ns with similar (delivery strateg	ies and interver	ntions (MDAs, N	Iorbidity mana	gement, social							
mobilization for Behaviour Change and Communication, V	VASH, IVM, EP	I, MCH service	s, etc) for integ	rated approache	es 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 maproducts and medicines	anagement syste	ems to ensure ti	mely, safe, and	effective supply	of quality assur	red NTD							
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, implement	ntation, and mor	nitoring											
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 coordinat	ion and respons	e (WASH, One	Health, Ministr	y of Education,	Finance, Agrice	ulture, 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, Con	nmunity organi	zations)								
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 coordinati	on for NTD pro	ogramme imple	mentation										
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							
Eswatini FY 2023 TIPAC generated: 3/24/2023 3:42:05 PM													
Inflation rate 4.22% Category: Implementation costs Operational costs													

					Timeli	ne for i	mpleme	entation					Estimated cost
Activities - Sub-activities - Districts	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	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													200.000
STH C. I. I. I. C. C. UNTER													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

	Timeline for implementation												Estimated cost
Activities - Sub-activities - Districts	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	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

					Timeli	ine for i	mpleme	entation					Estimated cost
Activities - Sub-activities - Districts	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	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

		Timeline for implementation										Estimated cost	
Activities - Sub-activities - Districts	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	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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Inkundla	Prevalence	e Rates	Method used	Year of survey &
	STH %	SCH %	-	Reference
Dvokodvweni	6.00%	8.70%	School-based Population Mapping Survey	1 2015
Ekukhanyeni	3.10%	11.20%	School-based Population Mapping Survey	1 2015
Endzingeni	5.00%	7.60%	School-based Population Mapping Survey	1 2015
Gege	0.40%	12.60%	School-basedPopulationMapping Survey	1 2015
Hhukwini	24.60%	6.90%	School-based Population Mapping Survey	1 2015
Hlane	5.60%	17.70%	School-based Population Mapping Survey	1 2015
Hosea	0.00%	19.20%	School-based Population Mapping Survey	1 2015
Kubuta	0.40%	20.60%	School-based Population Mapping Survey	1 2015
Kwaluseni	3.00%	10.20%	School-based Population Mapping Survey	1 2015
Lamgabhi	2.30%	14.00%	School-based Population Mapping Survey	1 2015
Lobamba	8.00%	6.50%	School-based Population Mapping Survey	1 2015
Lobamba Lomdzala	11.10%	16.40%	School-based Population Mapping Survey	1 2015
Lomahasha	6.10%	30.90%	School-based Population Mapping Survey	1 2015
Lubuli	5.70%	7.40%	School-based Population Mapping Survey	1 2015
Ludzeludze	1.50%	11.90%	School-based Population Mapping Survey	1 2015
Lugongolweni	10.00%	25.00%	School-based Population Mapping Survey	1 2015
Madlangempisi	6.00%	6.00%	School-based Population Mapping Survey	1 2015

Annex 1 STH and SCH prevalence by Tinkhundla

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

Inkundla	Prevalence Rates		Method used	Year of
	STH %	SCH %		Reference
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-basedPopulationMapping Survey	2015
Nkhaba	6.40%	3.00%	School-basedPopulationMapping Survey	2015
Nkilongo	8.00%	12.20%	School-basedPopulationMapping Survey	2015
Nkwene	1.50%	17.20%	School-basedPopulationMapping 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-basedPopulationMapping 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 survey	of &
	STH %	SCH %			Referenc	e
Timphisini	15.10%	23.10%	School-based Mapping Survey	Population	2015	
Zombodze	1.90%	23.60%	School-based Mapping Survey	Population	2015	

Annex 2: NTD	Endemicity	Statuses	and Five-y	year target	por	oulations	by	inkhundla
				0			~	

Inkhundla	LF	SCH	STH	Leprosy	Snakebite	Taeniasis	Foodborne	Scabies	2023	2024	2025	2026	2027
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	М	1	3	М	1	1	М	1	12,159	12,248	12,337	12,427	12,518
Hhohho: Lobamba	М	2	2	М	1	1	М	1	32,473	32,710	32,949	33,190	33,432
Hhohho: Madlangempisi	М	2	2	М	1	1	М	1	23,821	23,995	24,170	24,346	24,524
Hhohho: Maphalaleni	М	2	2	1	1	1	М	1	19,647	19,791	19,935	20,081	20,227
Hhohho: Mayiwane	М	2	2	М	1	1	М	1	17,248	17,374	17,501	17,629	17,757
Hhohho: Mbabane East	М	2	2	М	1	1	М	1	36,369	36,634	36,902	37,171	37,442
Hhohho: Mbabane West	М	2	2	М	1	1	М	1	26,371	26,563	26,757	26,953	27,149
Hhohho: Mhlangatane	М	2	2	М	1	1	М	1	25,684	25,872	26,061	26,251	26,442
Hhohho: Motshane	М	2	3	М	1	1	М	1	28,019	28,224	28,430	28,638	28,847
Hhohho: Ndzingeni	М	1	2	М	1	1	М	1	19,146	19,286	19,427	19,569	19,712
Hhohho: Nkhaba	М	1	2	М	1	1	М	1	20,661	20,812	20,964	21,117	21,271
Hhohho: Ntfonjeni	М	2	2	М	1	1	М	1	22,426	22,590	22,755	22,921	23,088
Hhohho: Pigg's Peak	М	2	2	М	1	1	М	1	19,888	20,033	20,179	20,327	20,475
Hhohho: Siphocosini	м	2	3	М	1	1	М	1	26,474	26,667	26,862	27,058	27,255
Hhohho: Timphisini	М	2	3	М	1	1	М	1	12,838	12,931	13,026	13,121	13,217
Lubombo: Dvokodvweni	М	2	2	М	1	1	М	1	31,558	31,789	32,021	32,255	32,490
Lubombo: Gigal	М	2	2	М	1	1	М	1	11,392	11,475	11,559	11,644	11,729
Lubombo: Lomahasha	М	2	2	М	1	1	М	1	22,379	22,543	22,707	22,873	23,040
Lubombo: Lubuli	М	2	2	М	1	1	М	1	14,333	14,438	14,543	14,649	14,756
Lubombo: Lugongolweni	М	2	2	М	1	1	М	1	27,670	27,872	28,075	28,280	28,487
Lubombo: Matsanjeni North	М	2	2	М	1	1	М	1	15,701	15,815	15,931	16,047	16,164
Lubombo: Mhlume	м	2	1	М	1	1	М	1	16,674	16,796	16,919	17,042	17,167

Inkhundla	Ъ	SCH	STH	Leprosy	Snakebite	Taeniasis	Foodborne	Scabies	2023	2024	2025	2026	2027
Lubombo: Mpolonjeni	М	2	2	М	1	1	М	1	14,224	14,328	14,433	14,538	14,644
Lubombo: Nkilongo	М	2	2	М	1	1	М	1	14,911	15,020	15,130	15,240	15,351
Lubombo: Siphofaneni	М	2	2	М	1	1	М	1	32,866	33,106	33,348	33,591	33,836
Lubombo: Sithobela	М	2	2	М	1	1	М	1	28,360	28,567	28,776	28,986	29,198
Manzini: Kukhanyeni	М	2	1	М	1	1	М	1	19,321	19,462	19,604	19,747	19,891
Manzini: Kwaluseni	М	1	2	М	1	1	М	1	60,660	61,103	61,549	61,999	62,451
Manzini: Lamgabhi	М	2	1	М	1	1	М	1	11,490	11,573	11,658	11,743	11,829
Manzini: Lobamba Lomdzala	М	2	2	М	1	1	М	1	22,056	22,217	22,379	22,542	22,707
Manzini: Ludzeludze	М	2	1	М	1	1	М	1	23,390	23,561	23,733	23,906	24,081
Manzini: Mafutseni	М	2	2	М	1	1	М	1	22,317	22,479	22,644	22,809	22,975
Manzini: Mahlangatsha	М	2	2	М	1	1	М	1	18,055	18,187	18,320	18,454	18,588
Manzini: Mangcongco	М	2	1	М	1	1	М	1	20,806	20,957	21,110	21,265	21,420
Manzini: Manzini North	М	2	1	М	1	1	М	1	34,726	34,979	35,235	35,492	35,751
Manzini: Manzini South	М	2	1	М	1	1	М	1	26,430	26,622	26,817	27,013	27,210
Manzini: Mhlambanyatsi	М	1	1	М	1	1	М	1	10,035	10,109	10,182	10,257	10,332
Manzini: Mkhiweni	М	2	2	М	1	1	М	1	23,987	24,162	24,339	24,517	24,696
Manzini: Mtfongwaneni	М	2	2	М	1	1	М	1	15,704	15,818	15,934	16,050	16,167
Manzini: Ngwemphisi	М	2	1	М	1	1	М	1	19,966	20,112	20,258	20,406	20,555
Manzini: Nhlambeni	М	2	1	М	1	1	М	1	12,778	12,871	12,965	13,060	13,155
Manzini: Ntondozi	М	2	2	М	1	1	М	1	14,957	15,067	15,176	15,287	15,399
Manzini: Nkomiyahlaba	М	2	1	М	1	1	М	1	14,030	14,132	14,236	14,339	14,444
Manzini: Phondo	М	2	1	М	1	1	М	1	23,534	23,706	23,879	24,053	24,229
Shiselweni: Gege	М	1	1	М	1	1	Μ	1	17,885	18,015	18,147	18,279	18,413
Shiselweni: Hosea	М	2	1	М	1	1	М	1	14,879	14,988	15,097	15,208	15,319
Shiselweni: Khubutha	М	2	1	Μ	1	1	Μ	1	5,910	5,953	5,997	6,040	6,084

Inkhundla	ц	SCH	STH	Leprosy	Snakebite	Taeniasis	Foodborne	Scabies	2023	2024	2025	2026	2027
Shiselweni: Maseyisini	М	2	1	М	1	1	Μ	1	29,898	30,117	30,336	30,558	30,781
Shiselweni: Matsanjeni South	М	2	2	М	1	1	М	1	10,623	10,700	10,779	10,857	10,936
Shiselweni: Methula	М	2	2	М	1	1	Μ	1	18,097	18,229	18,362	18,496	18,631
Shiselweni: Mbangweni/shiselweni 2	М	2	1	М	1	1	М	1	32,639	32,877	33,117	33,359	33,603
Shiselweni: Mtsambama	М	2	1	М	1	1	М	1	18,356	18,490	18,625	18,761	18,898
Shiselweni: Ngudzeni	М	3	1	М	1	1	М	1	8,956	9,021	9,087	9,153	9,220
Shiselweni: Nkwene	М	2	1	М	1	1	М	1	6,832	6,882	6,933	6,983	7,034
Shiselweni: Sandleni	М	2	1	М	1	1	М	1	18,053	18,185	18,318	18,452	18,586
Shiselweni: Shiselweni 1	М	2	1	М	1	1	М	1	9,361	9,430	9,498	9,568	9,638
Shiselweni: Sigwe	М	2	1	М	1	1	М	1	9,936	10,009	10,082	10,155	10,230
Shiselweni: Somntongo	М	2	2	М	1	1	М	1	8,440	8,501	8,563	8,626	8,689
Shiselweni: Zombodze Emuva	М	2	1	М	1	1	М	1	14,373	14,478	14,583	14,690	14,797



Annex 3: Eswatini NTD National Programme Organization Chart

Annex 4: NTD Commodities Forecasting Dashboard

	2023	2024	2025	2026	2027	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