



Ministry of Health

REPUBLIC OF MALAWI



MALAWI

Neglected Tropical Diseases

MASTER PLAN 2023 – 2030



<http://www.health.gov.mw/>

Table of Contents

<i>Figures and Tables</i>	4
<i>Abbreviations and Acronyms</i>	5
<i>Key Definitions</i>	6
<i>Executive Summary</i>	9
<i>Foreword</i>	10
<i>Acknowledgement</i>	11
<i>Introduction</i>	12
<i>PART 1: NTD SITUATION ANALYSIS</i>	14
Section 1.1. Re-assess National Priorities and the national, regional and global NTD Commitments	14
Section 1.2. National Context Analysis	15
1.2.1 Country Analysis	15
1.2.2 Health Systems Analysis	18
Section 1.3. Gap Assessment	24
Section 1.4. Programme Context Analysis	24
1.4.1. Current NTD Programme Organization and Status	41
1.4.2. NTD Co-endemicity in Malawi	48
1.4.3 Performance of the other programmes that are closely related to NTD programme	49
Section 1.5: Building on NTD Programme Strengths	54
1.5.1. Opportunities and Threats	54
1.5.2. Strengths and Weaknesses	54
1.5.3. Gaps and priorities	51
<i>PART 2 Strategic Agenda: Purpose and Goals</i>	53
Section 2.1: NTD Programme Mission and Vision	59
Section 2.2: Milestones and Targets	54
2.2.1. Overarching Targets	64
2.2.2. Cross-cutting Targets	64
Section 2.3: Guiding Principles	67
Section 2.4: Strategic Pillars and Strategic Objectives	63
2.4.1. Programme Strategic Pillars	63
2.4.2. Strategic Objectives	64
2.4.3 Programme Strategic Agenda Logic Map	70
<i>PART 3 Implementing the Strategy: NTD Operational Framework</i>	71
Section 3.1: Strategic Priorities and Key Activities	71
Section 3.2: Toward Programme Sustainability: Intensifying Coordination and Partnerships	85
Section 3.3: Assumptions, Risks and Mitigations	90
Section 3.4. Performance and Accountability Framework	93

<i>PART 4 Budgeting for Impact: Estimates</i>	98
<i>References</i>	103

Figures and Tables

Figures

- Fig 1. The PEST analysis
- Fig 2. Survey of presence of *G. morsatian* in Malawi
- Fig 3. Status of Schistosomiasis endemicity
- Fig 4. Status of Soil-transmitted Helminthiasis
- Fig 5. Trends in Endemicity status of Leprosy before 2021
- Fig 6. Trends showing Leprosy cases from 2021
- Fig 7. Hierarchy of Objectives for National NTD programs
- Fig 8. Program Strategic Pillars
- Fig 9. Program Strategic Agenda Logic Map of Malawi NTD Master Plan
- Fig 10. Proposed NTD structure for Malawi

Tables

- Table 1. Six Health System Building Blocks
- Table 2. Prevalence of r-HAT between 2017 and 2021
- Table 3. 2018 Oncho EPI Evaluation Using Ov 16 RDT and Elisa
- Table 4. Prevalence distribution of Schistosomiasis in Malawi
- Table 5. Impact of the interventions from the baseline
- Table 6. Prevalence Distribution of Soil Transmitted Helminthes in Malawi
- Table 7. National population data, and number of health facilities at district level
- Table 8. Known disease distribution in Malawi
- Table 9. NTD mapping status
- Table 10. Vectors and Associated NTDs
- Table 11. Summary of intervention information on existing NTD programs
- Table 12. SWOT counteracting table
- Table 13. Gaps and priorities
- Table 14. Mission and Vision
- Table 15: Milestones For Human African Trypanosomiasis
- Table 16: Milestones For Onchocerciasis
- Table 17: Milestones For Trachoma
- Table 18: Milestones For Lymphatic Filariasis
- Table 19: Milestones For Leprosy
- Table 20: Milestones For Soil Transmitted Helminths
- Table 21: Milestones For Schistosomiasis
- Table 22. Overarching targets for the country with a 2030 timeline
- Table 23. Cross-cutting targets for the country with a 2030 timeline
- Table 24. Disease-Specific Targets
- Table 25. Guiding Principles
- Table 26. Strategic Objectives for the Elimination of Neglected Tropical Diseases
- Table 27. Accelerating programmatic action
- Table 28. Membership and Terms of Reference – Program Coordination Mechanism
- Table 29. Partnership Matrix
- Table 30. Risk Criteria and Assessment
- Table 31. Steps to mitigate risk
- Table 32. Performance Indicators
- Table 33. Summary of Budget estimates for the major activities
- Table 34: Detailed budgeting of activities

Abbreviations and Acronyms

BICO	Blantyre Institute for Community Outreach
CBM	Christian Blind Mission
CM	Case Management
DNDi	Drugs for Neglected Diseases Initiatives
Dra	Dracunculiasis
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GLIDE	Global Initiative for Disease Elimination
GNP	Gross National Product
GPW 13	Thirteenth General Programme of Work 2019–2023
HAT	Human African Trypanosomiasis
IRS	Indoor residual spraying
ITN	Insecticide-treated net
IVM	Integrated vector management
Leish	Leishmaniasis
LF	Lymphatic filariasis
MDA	Mass drug administration
MMDP	Morbidity management and disability prevention
NTD	Neglected tropical diseases
Oncho	Onchocerciasis
PCT	Preventive chemotherapy
PEST	Political, Economic, Social and Technological Analysis
PHC	Primary Health Care
PMI	Presidential Malaria Initiative
PMRA	Pharmacy Medicines Regulatory Authority
PSI	Population Services International
SAV	Snake Antivenom
SCH	Schistosomiasis
SDGs	Sustainable Development Goals
STH	Soil-transmitted helminthiasis
SWOT	Strengths, weaknesses, opportunities, and threats
TAS	Transmission Assessment Survey
TIPAC	Tool for Integrated Planning and Costing
TOR	Terms of Reference
TRA	Trachoma
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
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 as a result 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 incidence of infection caused by a specific pathogen in a defined geographical area, with minimal risk of reintroduction, as a result 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, as a result of deliberate efforts, with no risk of reintroduction.

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

Integration: the process by which disease control activities are functionally merged or coordinated within multifunctional health-care delivery.

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, anaemia, chronic pain or fatigue) or subtle (such as stunted growth, impeded school or work performance or increased susceptibility to other diseases).

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

Platform: Structure through which public health programmes 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

Malawi is still plagued by Neglected Tropical Diseases (NTDs) and the most victims are the poorest and most marginalized communities. The burden of NTDs hampers socio-economic development in the country.

The increased attention being paid to NTDs for elimination as outlined in the Global NTD roadmap 2030 provides new opportunities to speed up the elimination of these diseases and contribute toward the top priority of the government of Malawi to ensure access to a health system that works for everyone.

Ministry of Health through various NTD activities in collaboration and with support from various stake holders has conducted mass deworming of school children against Schisto and soil transmitted helminthiasis annually, case management of schistosomiasis, leprosy, and sleeping sickness. Community mass treatment for onchocerciasis and lymphatic filariasis has been intensified as such significant progress has been made towards achieving elimination, where LF, Trachoma and Leprosy are eliminated hence improving the quality of life through the control of NTDs. However, much remains to be done towards eliminating the other NTDs in all communities. The need for progress towards elimination is urgent in order for the country to impact positively on the following goals:

- National Development Goals 2063, and
- WHO elimination roadmap for 2030.

This NTD Master Plan articulates a roadmap to shift from control focus to an elimination paradigm of NTDs in Malawi. The strategic plan, which was developed with the support of the World Health Organization and other Partners, is intended as a guide for the health personnel and relevant stakeholders such as academic institutions, laboratories, and Agriculture, Forestry, Fisheries and other government departments.

This master plan from 2023-2030 aligns with the Health Sector Strategic Plan (HSSP III); differs from the preceding master plan in that it focuses on elimination, locally owned and driven program, building local capacity to have nearly all elimination and disease management done locally, to be evidence based on impact indicators rather than operational indicators, it also put emphasis on shifting the programme financing to local rather than being multination donor dependent.

We trust this master plan will assist health workers and stakeholders to plan for effective control and working towards the elimination of neglected tropical diseases.

FOREWORD

The National Multiyear Strategic Plan of Action for Control of Neglected Tropical Diseases (NTDs) has been developed in line with the Ministry of Health's vision to transform Malawi into a nation free from NTDs by 2030 with regard to the Millennium Development Goals (MDGs). The strategy aims at guiding the implementation of NTDs in an integrated way to maximize on benefits. It is a product of extensive consultations with partners and stakeholders. This National Multi-year Strategic Plan of Action for Control of Neglected Tropical Diseases comes at a time when there is global goodwill for control of NTDs. As such it is my hope that all stakeholders will play their respective roles and responsibilities in supporting the implementation of this Multi-year Strategic plan.

In Malawi, there are over 10 NTDs that are known to be endemic. These diseases constitute serious impediment to socioeconomic development and quality of life. NTDs have enormous impact on individuals, families and communities in terms of disease burden, loss of productivity and the aggravation of poverty and high cost of long term care. NTDs cause disfigurement and disability leading to stigma and social discrimination. The ones being addressed include Schistosomiasis (bilharzia), Soil Transmitted Helminthiasis, Lymphatic Filariasis (Elephantiasis), Trachoma, Human African Trypanosomiasis (Sleeping sickness, Leprosy and Skin Diseases and Onchocerciasis (River Blindness). During the life span of this document, MoH will widen the scope on other diseases not yet mapped.

The commitment of the Government of Malawi is to uplift the socioeconomic status of all her citizens as clearly articulated in vision 2063. In compliance with this national vision, the MOH will spearhead the implementation of the National Multi-year Strategic Plan of Action for Control of Neglected Tropical Diseases with the goal of making Malawi free from NTDs through implementation of WHO recommended public health strategies for prevention and control of NTDs. These include Preventive chemotherapy, Case management, Vector control, Provision of Safe water, Sanitation and Hygiene and Veterinary public health. Evidence suggests that more effective control results are achieved when all five approaches are combined and delivered. The Ministry will therefore mobilize development partners (sector wide approach) to raise the resources needed for the realization of the goals of the country plan.

The Ministry of Health in collaboration with Ministry of Local Government and stakeholders will put in place a system for supervision, monitoring and evaluation of all programme activities. All sector partners including local communities will be involved in raising awareness through concerted Health Promotion and Education (HPE) strategies. It is my expectation that this comprehensive NTD control plan will be a major step towards the goal of eliminating NTDs in Malawi and I urge all stakeholders to put all their efforts into its implementation to enable the country to achieve its vision of a nation free of NTDs.

Signed

Minister of Health

ACKNOWLEDGEMENT

A consultative process involving stakeholders in Neglected Tropical Diseases (NTDs) and consultants was central in the development of this NTD Master Plan document. On behalf of the Ministry, I would like to thank the Dr S. Kabuluzi, the Director of Preventive Health Services for providing policy guidance and technical directions.

I would thank all the stakeholders who attended the stakeholders meeting for their valuable contributions and in the same vein thank the following for their dedication to the development of the first draft of the Master Plan, Mr. Bright Benson Chiwaula, Country Director, Sightsavers Malawi; Mr. John Chipeta Sightsavers Malawi, Ms Mercy Mziya, Ms Sunganani Manjolo of Leprosy and Skin Diseases Control Programme, Mr. Juziwelo (late), Schistosomiasis Control Programme, Soil Transmitted Helminthiasis Control Programme Manager, Mr. Marshial Lemerani, Manager Human African Trypanosomiasis Control Program (HAT), Mr. John Chiphwanya, Manager Lymphatic Filariasis Control Programme, Mr. Laston Sitima Manager Onchocerciasis Control Programme, and Mr. Michael Masika, Manager Trachoma Control Programme. Sincere appreciation to Mr. Jonathan Gwaligwali of University of Malawi Geography department-Cartographic for producing the maps

Special thanks go to GIZ for financial support, SightSavers, GLIDE international, the World Health Organization (WHO) Country Representative, Dr Neema Kimambo for facilitating the work of consultants and other experts who assisted in the development of this NTD Master Plan. Others are Mr Ishmael Nyasulu and Dr Michael Kayange NTD Malawi WHO office, Prof. Sammy Sam-Wobo from Nigeria, who was assigned by WHO/ESPEN to provide technical support alongside with Prof Dylo Pemba, the Local consultant in finalizing the development of this NTD Master Plan. I also thank Mr Laston Sitima Malawi focal person for NTD Masterplan development for his untiring effort in organizing all the processes in the development of this master plan.

Signed
Secretary for Health

List of Contributors

The consultative process involves several meetings in Salima that focused on disease technicalities and the budgeting session, which involved orienting participants on WHO TIPAC budgeting tool and it took place at Liwonde.

Below is the list of all contributors

No	Name	Designation	Work station	Phone number
1	Marshal Lemerani	HAT Program Manager	CHSU	0888 424 710
2	Fredrick Jumah	HAT Coordinator	Rumphi	0999 719 708
3	Westain Nyirenda	DHSS	Rumphi	0992 452 453
4	Drifton Zgambo	HAT Coordinator	Nkhotakota	0882 006 044
5	Mercy Mziya	Leprosy Coordinator	CHSU	0999 945 878
6	Levi Lwanda	M & E Officer	Mangochi	0888 873 267
7	Bob Nkumbeza	DVD	Mangochi	0994 508 486
8	Tisungane Mwenyenkulu	Leprosy	CHSU	0995 266 623
9	Sunganani Manjolo	Leprosy	CHSU	0999 117 070
10	Laston Sitima	Oncho Program Manager	CHSU	0888 303 446
11	Moses Ngwira	DOC	Chiradzulu	0888 213 713
12	David Chinyanya	Independent participant		0888 667 541
13	Margret Mikwamba	DEHO	Neno	0995 187 547
14	Samuel Jemu	Program Officer	PBHRT	0888 875 803
15	John Chiphwanya	LF Program Manager	CHSU	0888 385 458
16	Limbikani Chaponda	Lab. Officer	CHU	0999 521 700
17	Semion Lijenje	Clinician	KCH	0999 942 751
18	Dorothy Matipula	Clinician	Zomba	0888 409 403
19	Dylo Pemba	Consultant	University of Malawi	0888 314 283
20	Vincent Moyo	Ophthalmologist	Nkhoma mission Hospital	0999 647 476
21	Lazarus Juziwelo	Shisto/STH Program Manager	CHSU	0999 663 061
22	Andrew Nguluwe	Data Officer	CHSU	0999 757 991
23	Stanley Banda	M & E Officer	CHSU	0888 651 010
24	Themba Mzilahowa	Researcher	KUHES	0999 218 808
25	Seke Kayuni	Medical Officer	MASM	0888 567 367
26	Jacob Mazalale	Consultant	University of Malawi	0994 520 367
27	Alex Maferano	NTD Coordinator	Machinga	0991 738 481



Group photo of Participants at the Consultative meetings



Photo from L-R shows Prof Dylo Pemba, Prof Sam-Wobo, WR Dr Neema Kimambo (WR), Mr Nyasulu and Dr Kayange after the inception meeting with the WR

INTRODUCTION

The African Region bears close to 40% of the global burden of neglected tropical diseases (NTDs). All the 47 countries in the Region are endemic for at least one NTD; over 10 of these NTDs are currently known to be endemic in Malawi.

By impairing the physical and intellectual capacities of the affected persons and because they thrive in areas where access to quality healthcare, clean water and sanitation is limited, NTDs perpetuate a cycle of poverty.

Comprehensive multi-year plans for the control, and elimination (and eventual eradication of all NTDs) that are relevant in country, called NTD Programme Master Plans, are essential strategic documents for governments to effectively plan and implement sustainable NTD programmes in the African region.

Malawi NTD programme's comprehensive multi-year plan (the NTD Master plan) provides programme goals, objectives and year strategy based on extensive situation analysis, and addresses all components of the NTD programmes relevant to the country.

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 Malawi NTD Master plan also forms the basis for harmonized implementation and performance monitoring of all NTD interventions.

The proposed NTD Master Plan (2023-2030) governs the prevention, control and, where feasible, elimination and eradication of neglected tropical diseases. 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 the Master Plan is to be a tool for the government to plan for all NTD programmes in the country which facilitate alignment among partners and stakeholders for a joint and complementary support to countries and to accelerate progress towards the prevention, control, elimination and eradication of all relevant NTDs in Malawi. It provides all partners working on NTDs in the African region with a harmonized tool that will facilitate joint support to countries.

The Master Plan outlines specific, measurable targets for the eradication, elimination and control of all NTDs endemic in Malawi, as well as cross-cutting targets aligned with WHO's Thirteenth General Programme of Work 2019-2023, and the SDGs.

This proposed Master plan includes the strategies and approaches for achieving set targets, with cross-cutting themes for several diseases, and moves towards the prevention of infections and alleviation of the suffering of people affected by WHO's expanded portfolio of 20 diseases and disease groups, as well as how this contributes to attaining the SDGs.

Master Plan is inclusive of all diseases categorized as NTDs by the WHO. Progress in implementing planned activities as well as the programme performance and outputs will be monitored regularly and evaluated at appropriate intervals by the Malawi government. The strategic plan will be the framework for coordination, harmonization, and alignment of central and district level, as well as partners.

The integration of NTDs into the national health system is critical, therefore the NTD Master Plan should be integrated and reflected into the national health development plans.

PART 1:

NTD SITUATION ANALYSIS

Section 1.1. Re-assess National Priorities and the national, regional and global NTD Commitments

This Master Plan is an update of the previous NTDs Master Plan (2015-2020). The development of the previous Master Plan was guided by global priorities informed by various reforms including: the Ouagadougou Declaration on Primary Health Care (WHO, 2008) with emphasis on Primary Health Care within the context of health systems strengthening; the World Health Assembly Resolution 58:33² of 2015 on increasing access to needed services; and the World Health Assembly resolution (WHA 66.12)³ passed in 2013 to control, eliminate, and eradicate NTDs by 2020. Most recently, NTDs gained prominent priority as evidenced by its inclusion in the United Nations Agenda for Sustainable Development Goal 3 (SDG3) wherein it was stated that "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases (UN, 2015). Based on learnings from the past implementation of NTD interventions, the current WHO Roadmap for NTDs 2021-2030 urges countries to prioritize integrated approaches for the control, elimination and eradication of NTDs by 2030 (WHO, 2020)

Since Africa contributes to at least 40% of the global NTD burden, there is growing interest in NTDs and regional policy makers have included NTDs on the list of regional priorities (WHO, 2018). In the recently developed Africa Union's Agenda 2063 (African Union, 2013); NTDs aligns with Aspiration One, which is aimed at improving the quality of life for all citizens. Following the Kigali Declaration on NTDs which aligned with the WHO Roadmap for Neglected Tropical Diseases (2021-2030) to mobilize political will and secure commitments to end NTDs in the African Region; while the Abuja Declaration of 2001 required the African Union member states to allocate at least 15% of their national budgets to health. Furthermore, in 2013, the 6th session of the Conference of Africa Union Ministers of Health (CAMH6), convened with the theme: "Impact of Non-Communicable Diseases and NTDs on Africa's Development," also endorsed a continental framework for NTD control and elimination.¹¹

Malawi's National Health Policy includes NTDs in priority area 5, with a goal "to improve prevention, case detection and coordinated response for the prevention, control and management of communicable diseases and NTDs.

The strategic goal of the NTD programme is to progressively reduce morbidity, disability and mortality due to NTDs using integrated and cost-effective approaches with the view to eliminating NTDs in Malawi by the year 2030. Over ten (10) NTDs are endemic in Malawi. The National NTD programme currently addresses the following diseases: Lymphatic Filariasis, Onchocerciasis, Schistosomiasis, Soil Transmitted Helminths, Trachoma, Leprosy, Human African Trypanosomiasis except Buruli Ulcer, Rabies, Yaws and Leishmaniasis.

The Malawi NTD master plan 2023-2030 focused on four (4) major parts: NTD situation analysis; Strategic Agenda; NTD operational framework; and budgeting for impact. It also contains programme goals, objectives, and a 5-year strategy based on a detailed scenario analysis.

Considering the nature of NTDs, the goal of their elimination is built around collaboration with other relevant sectors as well as building a strong, resilient, and robust health service delivery system that is accessible to all, including the marginalized and disadvantaged segments of the population.

Section 1.2. National Context Analysis

1.2.1 Country Analysis

COUNTRY PROFILE

Malawi is a landlocked, long stretched country in southeastern Africa in the Great Rift Valley on the western shore of Lake Nyasa (Lake Malawi), the most southerly lake in the Great African Rift Valley system. Malawi shares international borders with Tanzania, Zambia and Mozambique. The country covers an area of 118,484 km², Lake Malawi (formerly referred to as Lake Nyasa) comprises about 20% of total area. The terrain comprise of plateaus, highlands, and valleys. The nation is divided in three main regions: Northern, Central and Southern. There are also three different geographical regions, the Rift Valley, the Central African Plateau, and the Highlands. Largest river in Malawi is the Shire river, the only outlet of Lake Malawi. Highest mountain is Mount Mulanje at 3,002 m (9,849 ft). Malawi is one of the world's most densely populated nations with an estimated population of 18.6 million (2019), which is expected to double by 2038. Climate: Predominately sub-tropical; two main seasons, cold-dry and hot-wet. The hot-wet season is from November to April.

Political:

Politics of Malawi takes place in a framework of a presidential representative democratic republic, whereby the President of Malawi is both head of state and head of government, and of a multi-party system. Executive power is exercised by the government. Legislative power is vested in both the government and the National Assembly. There is a cabinet of Malawi that is appointed by the President of Malawi. The judiciary is independent of the executive and the legislature. Local government is carried out in 29 districts within three regions administered by district commissioners who are appointed by the central government. The districts are Balaka, Blantyre, Chikwawa, Chiradzulu, Chitipa, Dedza, Dowa, Karonga, Kasungu, Likoma, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Mwanza, Mzimba North, Mzimba South, Neno, NkhataBay, Nkhatakota, Nsanje, Ntcheu, Ntchisi, Phalombe, Rumphi, Salima, Thyolo, Zomba

The introduction of a multiparty system in 1994 has resulted in a stable democratic government for the past two decades. This makes the country an increasingly reassuring destination for foreign investors. The government has recently begun reforming its financial management system and has put a series of fiscal incentives in place to attract foreign investors. The country has also introduced a series of policy instruments to promote FDI, including tax incentives and the Malawi Innovation Challenge Fund for private businesses, which nurtures productive partnerships between leading firms and poor producers and entrepreneurs. The need for research and services is enormous, in a country where 88% of the population still lacks access to electricity, 47% improved sanitation and one in four adults lacks any form of family planning.

Economic:

The Malawi Growth and Development Strategy (MGDS), a series of five-year plans, guides the country's development. The current MGDS III, Building a Productive, Competitive and Resilient Nation, will run through 2022 and focuses on education, energy, agriculture, health and tourism. In January 2021, the government launched the Malawi Vision 2063 that aims at transforming Malawi into a wealthy and self-reliant industrialized upper middle-income country. ([Malawi Overview: Development news, research, data | World Bank](#))

With about 80% of the population living in rural areas, the economy of Malawi is predominately agricultural: in 2019, the sector accounted for 25.5% of GDP, 80% of export revenues and 76% of employment (World Bank). The main export and most cultivated crop is tobacco - this, in a context where the country is looking to diversify its economy. Aside from tobacco, other revenue-generating crops include tea, coffee, sugarcane, cotton, sorghum, potatoes and corn (maize). Historically, the country produces enough food to feed its population, though harvests can be seriously affected by adverse weather conditions, like it was the case in 2015 and 2016 with El Nino-induced droughts.

Though still underdeveloped, the industrial sector contributed an estimated 12.9% of GDP in 2019. The majority of Malawi's industrial activity comes from manufacturing and food processing. Despite the government's efforts to boost competitiveness, several challenges kept hindering the sector, including poor business climate, a lack of well-developed infrastructure, and the lack of skilled labour to operate machinery. Mining activities are at a small-scale level and not fully developed. However, the country has some deposits of bauxite, asbestos, graphite, and uranium. The industrial sector only employs 5% of the workforce. The services sector is the major contributor to the country's GDP (54.4% in 2019). The main activities include tourism, health services, the banking sector, telecommunications, and retail, with the government of Malawi holding significant shares in most of these sectors.

In 2020, due to the COVID-19 pandemic, the service sector declining by 6%. The agricultural sector proved more resilient, expanding by 0.5%. Agriculture was nonetheless hurt by lower cotton prices, supply chain disruptions and the decline in tobacco prices and production. ([The economic context of Malawi - Economic and Political Overview - International Trade Portal](#)
[International Trade Portal \(lloydsbanktrade.com\)](#))

Social:

Malawi has made notable progress in building a solid social support system, anchored in the National Social Support Policy (2012), currently under review, and operationalized through the Second Malawi National Social Support Programme (MNSSP II) (2018-2023). Social protection in Malawi consists of four major programmes, namely the social cash transfer programme, public works programmes, school meals programmes and village savings and loan associations. The SCTP is the flagship social protection programme and is implemented nationwide by the Government. In recent years, the SCTP has been scaled up to respond to shocks including floods, lean season and more recently COVID-19. The Government is operationalizing a social registry called the Unified Beneficiary Registry (UBR) and social support programme Management Information Systems (MIS) and is piloting electronic payments, with the goal of scaling them up nationwide. As part of improving the effectiveness and efficiency of the social support system, the Government and its partners are currently in the process of defining an

operational vision for shock-sensitive social support as well as developing a national framework for nutrition-sensitive social support.

NTDs have significant social impact leading to stigma and discrimination and can be affected by social factors such as migration. Analysis of the social factors which determine the interventions of NTDs are critical. Health seeking behavior, Illiteracy and cultural beliefs impede beneficiaries from accepting intervention services. Weak health systems and infrastructure, challenges in access to health care facilities, high cost of services for beneficiaries, post-donor support, stigmatization and discrimination

Technological:

Malawi is one of the low income countries in the world yet spends 1% of its [gross domestic product](#) (GDP) on research and development (R&D). This is one of the highest ratios in Africa. Malawi thus has the potential to harness science, technology and innovation to reduce poverty and diversify its agriculture-dependent economy. The challenge is to attract sufficient foreign direct investment (FDI) to foster technology transfer and empower the private sector to serve as an engine of economic growth.



Figure 1: PEST Analysis for Malawi

1.2.1. Health Systems Analysis

Health system goals and priorities

Malawi operates a **three-tier health system**. The first tier is primary healthcare. This sector is in effect to meet the needs of general medical care, which includes community and rural hospitals and maternity units. The second tier consists of district hospitals. The MoH headquarters is responsible for the development, review and enforcement of health and related policies for the health sector; spearheading sector reforms; regulating the health sector including the private sector; developing and reviewing standards, norms and management protocols for service delivery and ensuring that these are communicated to lower level institutions; planning and mobilizing health resources for the health sector including allocation and management; advising other ministries, departments and agencies on health related issues; providing technical support supervision; coordinating research; and monitoring and evaluation. Even though the Reproductive health department, the Health education Services, the Research Department, the Community Health Sciences Unit under which NTDs fall, the National Tuberculosis and Leprosy Elimination Programme and the HIV Department are not physically at the MoH headquarters, they are part of the central level. The MoH is also responsible for ensuring that its obligations to global initiatives are fulfilled. The MoH established five zonal offices which are now run by the quality management officers. The quality management officers provide technical support to District Health Management Teams (DHMTs) in planning, delivery and monitoring of health service delivery at the district level and facilitation of central hospitals' supervision to districts.

1.2.2. Analysis of the Overall Health system

In Malawi health care services are delivered by the public and the private sector. The public sector includes all facilities under the MoH, Ministry of Local Government and Rural Development (MoLGRD), the Ministry of Forestry, the Police, Prisons and the Army. The private sector consists of private for profit and private not for profit providers. The public sector provides services free of charge while the private sector charges user fees.

Health system goals and priorities

The MoH headquarters is responsible for the development, review and enforcement of health and related policies for the health sector; spearheading sector reforms; regulating the health sector including the private sector; developing and reviewing standards, norms and management protocols for service delivery and ensuring that these are communicated to lower level institutions; planning and mobilizing health resources for the health sector including allocation and management; advising other ministries, departments and agencies on health related issues; providing technical support supervision; coordinating research; and monitoring and evaluation. Even though the Reproductive health Unit, the Health education Unit, the Research Unit, the Community Health Sciences Unit, the National Tuberculosis Programme and the HIV Department are not physically at the MoH headquarters, they are part of the central level. The MoH is also responsible for ensuring that its obligations to global initiatives are fulfilled. The MoH established five zonal offices. The role of the Zonal Offices is to provide technical support to District Health Management Teams (DHMTs) in planning, delivery and monitoring of health service delivery at the district level and facilitation of central hospitals' supervision to districts.

Service Delivery

Malawi's health system is organized at four levels namely: community, primary, secondary and tertiary. These different levels are linked to each other through an established referral system. Community, Primary and Secondary level care falls under district councils. The District Health Officer (DHO) is the head of the district health care system and reports to the District Commissioner (DC) who is the Controlling Officer of public institutions at district level.

Community level

At community level, health services are provided by health surveillance assistants (HSAs), health posts, dispensaries, and maternity clinics. Each HSA is meant to be responsible for a catchment area of 1,000 though most are still responsible for more people. HSAs are supported by Senior HSAs in post. HSAs mainly provide promotive and preventive health care through door-to-door visitations, village and outreach clinics and mobile clinics (Ministry of Health, 2011).

Primary level

At primary level, health services are provided by health centres and community hospitals. Health centres offer outpatient and maternity services and are meant to serve a population of 10,000. Community hospitals are larger than health centres. They offer outpatient and inpatient services and conduct minor procedures. Their bed capacity can reach up to 250 beds (Ministry of Health, 2011).

Secondary level

The secondary level of care consists of district hospitals and CHAM hospitals of equivalent capacity. Based on Table 6 in the HSSPII, secondary level health care facilities account for 9.5% of all health care facilities. They provide referral services to health centres and community hospitals and also provide their surrounding populations with both outpatient and inpatient services.

Tertiary level

The tertiary level consists of central hospitals. They ideally provide specialist health services at regional level and also provide referral services to district hospitals within their region. In practice, however, around 70% of the services they provide are either primary or secondary services due to lack of a gate-keeping system (Ministry of Health, 2011).

Ministry of Health headquarters

The functions of the central level include policy making, standards setting, quality assurance, strategic planning, resource mobilization, technical support, monitoring and evaluation and international representation. Five Zonal Quality Management Offices (QMOs) are an extension of the central level and provide technical support to districts.

District Health Offices

The functions of the district health offices (DHOs) include: managing all public health facilities at district level and directing provision of both primary and secondary level health services at district level. DHOs report to District Commissioners who are under Ministry of Local Government. At technical level, DHOs receive technical backstopping from Zonal Quality Management Office (QMDs) who are under the Ministry of Health.

Analysis of the overall health system

The analysis of the overall health system is summarized in table 1 below.

Table 1. Analysis of the country's health system using the Six Health System Building Blocks	
Service delivery	<p>MoH policy is that every Malawian should reside within an 8km radius of a health facility. The proportion of the population living within 8km radius of health facility (health centres and hospitals) stands at 90% in 2016, an increase from 81% in 2011. This indicates that there is still a proportion of the population that is underserved; especially those residing in the rural and hard to reach areas and 56% of Malawian adult women still cite distance to health facility as a key barrier to health access when they are sick. The private sector plays an important role in the delivery of health services. At community level, numerous NGOs, FBOs and CBOs deliver promotive health services. The Malawi Traditional Medicine Policy has since been put together and it will guide the practice of traditional medicine. The health sector will continue to work with traditional healers through the Malawi Traditional Healers Umbrella Organization</p> <p>Christian Health Association of Malawi (CHAM) is the biggest partner for the MoH: it provides services and trains health workers through its health training institutions (TIs). It owns 11 out of the 16 TIs in Malawi and most of these are located in rural areas. CHAM facilities charge user fees to cover operational costs and are mostly located in rural areas. The charging of user fees constitutes a major barrier to accessing services for most poor rural people; hence gross inequality to those living in catchment areas of CHAM facilities. GoM heavily subsidizes CHAM by financing some drugs and all local staffing costs in CHAM facilities.</p> <p>In order to increase access to EHP services, the MoH has encouraged DHOs to sign service level agreements (SLAs) with CHAM and BLM facilities to remove user fees for most vulnerable populations. To date 76 SLAs out of approximately 172 facilities have been signed mainly for the delivery of maternal and newborn health (MNH) services. A few facilities have SLAs for an entire EHP. SLAs involve the transfer of funds from the DHO to a CHAM facility in exchange for the removal of user fees. Currently, SLA guidelines with the private sector exist for AIDS and Tuberculosis.</p>
Health workforce	<p>For health goals to be achieved, adequate numbers of health workers with appropriate training should be available. Malawi is faced with significant shortages in healthcare workers (HCWs). The situation was so critical that to mitigate it, in 2004 MoH and stakeholders, developed a six-year Emergency Human Resource Plan (EHRP) to address the problem. With significant vacancies (see Figure below) among priority HCW cadres, particularly nurses, physicians, clinical officers, environmental health officers,</p>

	<p>laboratory and pharmacy technicians, Malawi's HRH challenges remains both acute and complex.</p> <p>Health surveillance assistants, environmental health officers and nurses are the cadres mainly based at the peripheral health facilities and are the staff involved in NTD prevention and control. A policy exists in the ministry for continuous recruitment and deployment for these cadres of staff.</p> <p>There are still weaknesses in leadership and management of human resources at all levels of the health system, poor and slow recruitment practices and mal- distribution of health workers; majority being in urban areas. The inequitable distribution of human resources particularly affects NTD affected areas that are generally hard-to-reach and hard-to-stay for health workers.</p>
Health information	<p>The Health Management Information System (HMIS) is an important source of data regarding the health sector, diagnosis of EHP conditions and diseases and other health systems information. This data is available on a monthly, quarterly and annual basis. National Disease summary and data capturing tools (registers) have been designed for capturing majority of the diseases that are reported in the country. Most of the information used in health services delivery is derived from health facilities. However, health and health related information and data generated in the communities are rarely linked with higher level management. Data and information on one of the NTDs namely intestinal worms is captured using this existing system. However other NTDs are not captured, the existing data capture and summary tools need to be revised to include them.</p> <p>In addition, the Department of Integrated Disease Surveillance and Response (IDSR) implements the Integrated Disease Surveillance, which is a mechanism devised to record and report on major diseases in the country. The Department carries out surveillance on Diseases of public health importance affecting the districts including the emerging and re-emerging diseases. This information is collected weekly from Districts. The IDSR also leaves out NTDs. If the IDSR is improved to include capturing of NTDs, the existing system of surveillance, data on NTDs will flow from the health facilities from where it will be passed to the National level and NTDs Co-ordination office. However, despite this elaborate information system, it has been noted that most NTDs have no indicators or have inadequate indicators in the data capturing tools.</p>
Medical products	<p>The MoH has overall responsibility for procurement of public health goods, works and services. The Ministry Headquarters is responsible for procurement of operational goods and services for central operations and procurement of common capital goods, works and services that cater across all cost centers while the Central Medical Stores (CMS) is responsible for procurement of</p>

	<p>medicines and medical supplies. Central Hospitals undertake their own procurement while DHOs handle procurement at district level. The Public Procurement Regulations of 2004 provide detailed rules and procedures for fulfilling the objectives and implementing the provisions of the Act. Capacity building in the field of procurement is ongoing. The MoH recognizes that procurement is weak hence the need for more TA support.</p>
Health Financing	<p>Currently the GOM allocation to the health sector stands at 25.4% of the total government budget, which is about 8.7 % of GDP and translates to 27 US\$ per capita. The bulk of the funding to ministry of health goes to development and running public health services and support to private health services, preventive health services that includes, communicable and vector –borne diseases control and Malawi expanded programme for immunization.</p> <p>Essential Health Package, specifically HIV/AIDS; (ii) ARI; (iii) Malaria; (iv) Diarrheal diseases; (v) Perinatal conditions; (vi) NCDs including trauma; (vii) Tuberculosis; (viii) Malnutrition; (ix) Cancers; (x) Vaccine preventable diseases; (xi) Mental illness and epilepsy; (xii) Neglected Tropical Diseases (NTDs); and (xiii) Eye, ear and skin infections, is allocated up to 54% of the total funding to the MOH. The funds allocated are mainly spent on surveillance and response/control of communicable and vector-borne disease; improving capacity to diagnose and treatment of communicable and vector-borne diseases. The interventions for each of these diseases are those that have been proven cost effective. There are some interventions that are not cost effective but have been included because they are necessary. The EHP will be provided free of charge over the period of the HSSP.</p> <p>The recent adoption of Sector Wide Approach Package concept, the ministry of health is striving for a stronger strategic orientation and networking. Since Malawi has subscribed to the International Health Partnership, which is to ensure implementation of the Paris declaration of Aid effectiveness, MOH is fostering partnership of all stakeholders involved in financing, implementing and utilization of public health services. The ministry is addressing, strengthening of joint planning, performance monitoring and financing of public health services; capacity building on leadership at all levels of the health system; and partnerships and governance structures.</p> <p>Health Sector funding /financing mechanisms as stipulated in the Health Sector Development Plan (HSDP) includes three channels of financial resource management: Channel 1: Pooled and managed by government or earmarked by agencies with direct disbursement; Channel II: Donor held financing provided directly used and accounted for them; Channel III: Direct donor programmed funds disbursed by Development Partners to finance specific contributions to HSDP usually through NGOs</p>

Leadership and governance	<p>The Secretary for Health is the Chief Executive Officer and the controlling Officer of the Ministry of Health. The principal secretary deputizes the Secretary for health. The director of preventive health services is in charge of all disease control activities and advises the secretary for health on matters of disease control. The proposed NTDs structure will have the NTDs Programme Manager working directly under the supervision of the Director of Preventive health services. The NTD programme will work in close collaboration with the departments of Ophthalmic services. The NTD Programme will have 6 Task forces and these are (1) Schistosomiasis & STH (2) Onchocerciasis (3) Lymphatic filariasis (4) Trachoma (5) Human African Trypanosomiasis (HAT) and (6) Leprosy and skin conditions. This framework will promote an integrated approach or co-implementation of control of NTDs in the country with a common M&E system.</p> <p>NTDs are included in the Health Sector Strategic Plan 2023-2030 and the existing government commitment and political will are supportive of NTD control activities in the country. An institutional framework exists however, there is need for formation of an NTD coordinating body or programme to accelerate implementation of NTD control activities in the country including creation of an environment to engage partners in control of NTDs.</p> <p>There is a policy on school health programme that addresses the control of Schistosomiasis and soil transmitted helminthes in school aged children. However for the other NTDs there is no national policy but NTDs are included in the national strategic plan. The Department of Preventive health services oversees the implementation of all disease control programmes.</p> <p>At district level the DHMTs are responsible for making District Health Plans. These are developed with inputs from stakeholders and peripheral health facilities. However, these plans include very little on NTDs, due to the fact that the indicators they base their plans on are directed from national level according to the availability of funds. Diseases with adequate funding generate indicators that are included in District operational.</p>
----------------------------------	---

This section provides information on the current status of the NTDs in the country, identifying the areas requiring concerted action as well as the disease-specific gap assessment across the various dimensions identified in the NTD Roadmap.

The results of document review confirmed that Malawi is the hotspot for Human African T. b. rhodesiense Trypanosomiasis, reporting highest cases of form of this trypanosomiasis in the world (Trypanosomiasis Control program, 2021). The occurrence of the disease is also associated with the presence of the vector, tsetse.

Tsetse: The survey confirmed the continued presence of *G. morsitans* (*g.m*) in all the foci listed below and shown in the Figure 2. Similarly, the previously recorded presence of *G. brevipalpis* (*G.b*) in pockets on the lake shore was again reported. However, the capture of *G. pallidipes* (*G.p*) in three of the large foci confirmed the presence of this species in Malawi for the first time. A secondary low density population of this species alone was found in a locality where no flies had been recorded before. All the foci listed are associated with wildlife or large forest reserves where some game animals still exist. Outside of such areas, little suitable habitat for the shade loving flies exists below the 1200m contour, the upper limit of the fly's range.

- (i) Waza Marsh Game Reserve:
G. morsitans / *G. pallidipes*
- (ii) Kasungu National Park:
G. morsitans
- (iii) Nkhotakota Game Reserve
G. morsitans / *G. brevipalpis*
- (iv) Phirilongwe Forest Reserve
G. morsitans
- (v) Namizimu Forest Reserve
G. morsitans
- (vi) Liwonde National Park
G. morsitans
- (vii) Lengwe National Park
G. morsitans / *G. pallidipes*
- (viii) Mwabvi Game Reserve
G. morsitans / *G. pallidipes*

(ix) Tuma Forest Reserve
G. morsitans
(x) Majete Game Reserve
G. pallidipes



24

cases were reported from Malawi and Uganda. In 2019 and 2020, there was a significant increase in the number of cases due to an outbreak in Malawi starting in late 2019 and calming down by March 2020 (table 2). This increase was in stark contrast to that of the other countries and to the decreasing trend of previous years. The outbreak allegedly linked to extraordinarily high temperatures and a parallel outbreak of foot-and-mouth disease in domestic animals causing food shortages in the population, which led to more hunting for food. The number of tsetse flies increased with detection in unusual zones, and tsetse–human contact increased due to these factors combined

The disease epidemiology varies a lot both in time and space. R-HAT is localized in wildlife reserves and the surrounding communities. In Malawi the disease predominantly occurs in Vwaza in Rumphi and Mzimba North districts in the Northern region, Kasungu Wildlife Reserve in Kasungu District and Nkhotakota Wildlife reserve that is in Nkhotakota but borders Ntchisi and Kasungu in the Central region.

The table 2: Prevalence of r-HAT between 2017 and 2021

FOCUS	NUMBER OF CASES				
	2017	2018	2019	2020	2021
Vwaza	7	9	58	65	12
Kasungu	0	0	1	0	0
Nkhotakota	4	6	32	25	39
Total	11	15	91	90	51

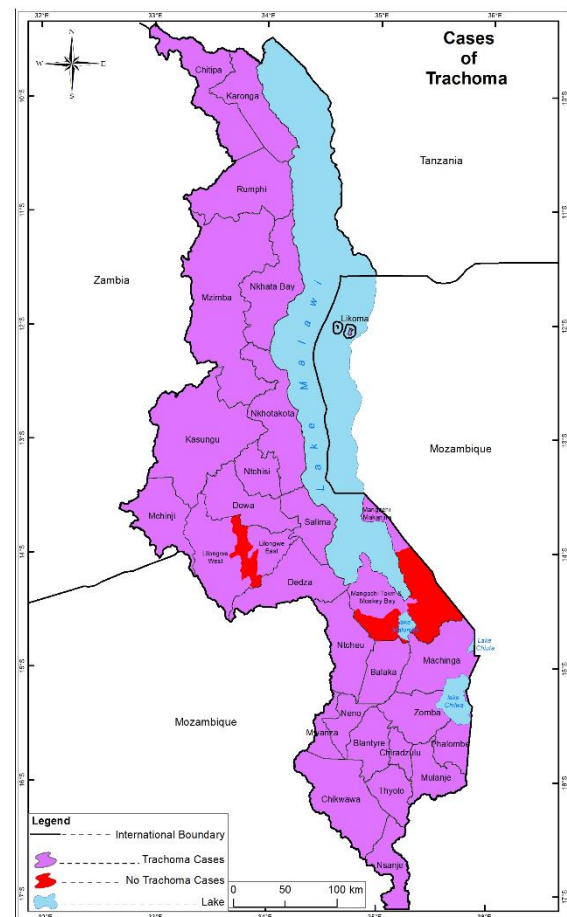
Programme response to Human African Trypanosomiasis

- Disease Surveillance
- Diagnosis and treatment of established cases
- Community mobilization and awareness
- Promotion and facilitation of r-HAT research activities
- Resource mobilization
- Coordination with donors and implementing partners

TRACHOMA

Trachoma used to be a major public health problem in Malawi. It is second cause of preventable blindness after cataract. Prevalence surveys conducted between 2008 to 2014 in 24 districts showed that trachoma is endemic ($\geq 5\%$ TF) in 15 districts.

This necessitated the implementation of SAFE Strategy (Surgery, Antibiotic distribution (MDA), Facial Washing and Environmental improvement). The SAFE strategy was launched in October 2014 to eliminate trachoma by the year 2020 in the surveyed districts. The remaining 5 out of 29 districts were mapped in 2015. By 2019, the programme has been able to reach out to the following 17 districts in the country (Karonga, Mzimba, Kasungu, Ntchisi, Nkhonkhotakota, Salima, Mchinji, Dowa, Lilongwe, Ntcheu and Dedza, Machinga, Mangochi, Mwanza, Neno, Chikwawa and Nsanje), provided more than 6000 people with surgery for advanced trachoma, distributed antibiotic treatment to over eight million people both children and adults and promoted facial cleanliness and use of sanitation facilities for children and adults to prevent infection. The ultimate objective has been to eliminate trachoma by 2019 by bringing infection down to below a public health crisis for Malawi to deal with it routinely in its hospitals, hence trachoma is at elimination stage and the country is preparing for certification.



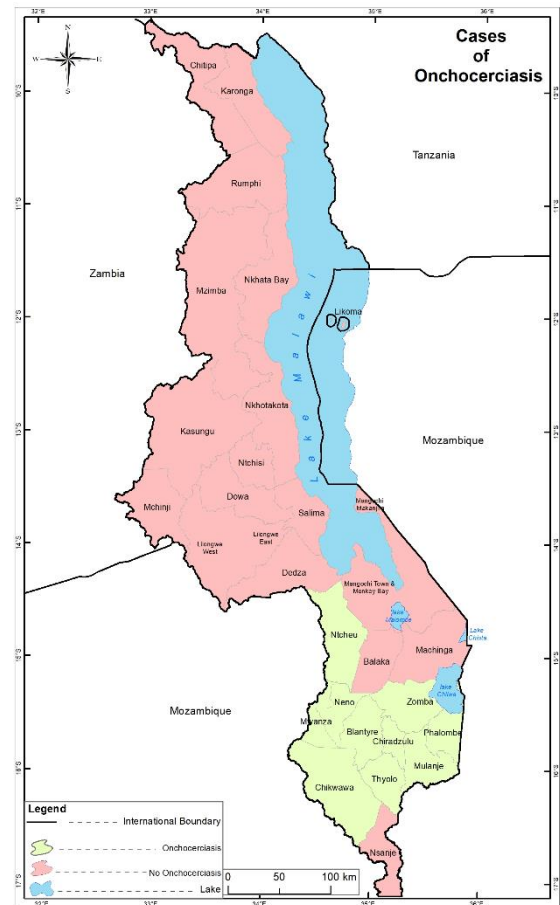
Response: What the Trachoma Programme Is Doing

1. Continued management of trachoma using
 - Surgery for people with trichiasis at immediate risk of blindness
 - Antibiotic therapy to reduce the community reservoir of infection and therefore stop transmission
 - Promoting wash activities namely Facial cleanliness and improved hygiene to reduce transmission
 - Environmental improvements, particularly water and sanitation, to make living conditions better so that the environment no longer facilitates the maintenance and transmission of trachoma
2. Facilitating trans boundary management of trachoma to stop cross border transmission as the country is entering elimination.

ONCHOCERCIASIS (RIVER BLINDNESS) DISEASE ENDEMICITY AND EPIDEMIOLOGY

Onchocerciasis in Malawi has been known from the early 1930s. The first large-scale investigations on the burden of the disease were carried out in 1980s and 1990s. In Malawi Onchocerciasis was first recognized in Thyolo Tea Estates and confirmed in 1984 using a Human Population Disease Survey and Vector Research and in 1990,

Mwanza was also identified to have cases of onchocerciasis. Based on these findings, in 1984, the GoM instituted the Malawi Onchocerciasis Control Programme. During the first years the programme focused much on assessing how many people were affected by the disease, determining infection rates, identifying vector species involved in transmission of the diseases and formulating recommendations regarding appropriate control measures. The key vector species responsible for transmission of onchocerciasis was found to be *Simulium damnosum*.



Situation Analysis				
Year	Affected Districts	Affected Population		Mortality
		Total At Risk Population Under MDA	Seroprevalence	
2015	8		7.2 %	0
2016	8	2,284,986		0
2017	8	2,361,936		0
2018	8	2,480,265	0.24 %	0
2019	10	2,567,803		0
2020	10	2,515,696		0

With assistance from African Programme for Onchocerciasis Control (APOC), a countrywide survey using Rapid Epidemiological Mapping of Onchocerciasis (REMO) was conducted in 1997. Results from this survey showed that besides Thyolo, Mwanza and Neno, the disease is endemic in parts of Mulanje, Phalombe, Blantyre, Chiradzulu and Chikwawa Districts. In 2018, a refinement of the mapping was conducted to include a new focus in Zomba and Ntcheu. Therefore, the disease is endemic in 10 of the 28 districts in Malawi.

In an effort towards elimination Ivermectin (Mectizan®) mass distribution using the Community Based Distribution (CBD) strategy started in Thyolo District in 1991 and Mwanza District in 1993 respectively.

The assessment of onchocerciasis transmission was conducted in 2011 and 2012 in 60 villages across all the endemic zones including the hypo-endemic areas. The results have been very satisfactory (57 villages with 0% prevalence), except in three villages that had prevalence of 1.05%, 8.18% and 8.67%. In 2015, Malawi conducted an assessment using skin snip and RDT methods. A total of 2,031 persons were examined for OV16 RDT and a total of 165 persons were positive representing 8.1%. OV 16 RDT showed that 12 villages of the 20 villages had positive cases and among the 12 villages, 4 villages have 1 positive case each. Five villages had high percentage of OV16 RDT positive cases among the 12 villages. A total of 2,584 persons were examined for skin snip and the skin snips in the 20 evaluated villages were negative. The 2015 skin snip results confirm the 2011 and 2012 results (table 3).

TABLE 3: RESULTS OF 2018 ONCHO EPI EVALUATION USING OV 16 RDT AND ELISA

District	1st line Screened	2 Line Screened	Total	1st line Positives	2 Line Positives	Total Positives	Seroprevalence RDT	ELISA
Blantyre	514	664	1178	1	3	4	0.34	
Chikwawa	77	571	648	0	0	0	0.00	
Chiradzulu	129	634	763	0	1	1	0.13	
Mulanje	175	451	626	0	1	1	0.16	4.15
Mwanza	233	120	353	2	0	2	0.57	4.82
Neno	611	106	717	1	1	2	0.28	
Ntcheu	960	634	1594	0	1	1	0.06	1.69
Phalombe	97	425	522	2	0	2	0.38	
Thyolo	1239	340	1579	0	2	2	0.13	
Zomba	999	1268	2267	7	3	10	0.44	0.44
Total	5034	5213	10247	13	12	25	0.24	1.65

Prevalence in Zomba in the recent epi survey was above the hypo endemic level hence confirming an established new focus.

Pool-screening results of samples collected in 2017 for Malawi

District	Capture Point	Observed number of flies - actually counted and analysed	Infectivity Rate (0/00)	Lower end of interval (0/00)	Upper end of interval (0/00)
Thyolo	Chidzinja	8045	0	0	0.3047
	Chisinkha	4194	0	0	0.3367
	Lingoni	13197	0.3102	0.07846	0.7983
	Magombo	7053	0	0	0.2782
Mulanje	Kadewere	6488	0.1550	0.0004780	0.7983
	Likhubula	11528	0.2740	0.05298	0.7956
	Padwale	34284	0.1859	0.06942	0.3906
	Mathithi	3317	0	0	0.5816
	Lomo	7693	0.2381	0.02810	0.8363
Blantyre	Madziabango	10191	0	0	0.1882
Mwanza	Malambe	55776	0.01796	0.000055	0.009251
Phalombe	Nkhulambe	10389	0	0	0.1882
	Mlelemba	25986	0.003898	0.0001202	0.2007
Chikwawa	Mwamphanzi	1069	0	0	1.59
Ntcheu	Nthawitsa	22273	0.3311	0.1236	0.6960
Zomba	H. Parker	29202	0.1763	0.05306	0.4165

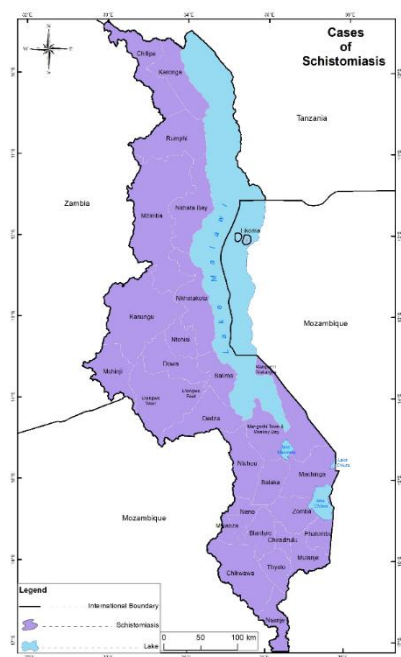
The main endemic zone in the country is thought to be a spill-over from Mozambique where mass treatment for onchocerciasis has never been conducted. Based on 1999 REMO results the area had been classified as hypo endemic. It is therefore critical that the current situation of Onchocerciasis in adjacent areas of Mozambique (Nyasa province) be evaluated.

Response: What the Oncho programme is doing

Currently the onchocerciasis control programme is

- Preparing for Stopping MDA in 60% of the endemic districts (Neno, Phalombe, Chiradzulu, Chikwawa, Blantyre and Mwanza) (2024)
- Stopping MDA in all endemic districts (2030)
- Working toward elimination by 2030
- MDA has been recently introduced in Zomba and Ntcheu districts (2023). It is envisaged that MDA for the two districts will continue beyond 2030
- Entomology and epidemiology Surveillance to make sure the majority of foci that have reached elimination levels maintain the status
- Community mobilization and awareness
- Promotion and facilitation of oncho activities
- Resource mobilization
- Coordination with partners within and outside the country

SCHISTOSOMIASIS (BILHARZIA)



Schistosomiasis Urogenital and intestinal, are the most common infections worldwide, affecting more than 200 million people globally including Malawi. Risk of infection is higher in areas of poor hygiene and sanitation, where people are poor schistosomiasis are endemic throughout Malawi (Figure 3).

Figure 3: Maps showing endemic districts in Malawi for schistosomiasis

Table 4: Prevalence distribution of Schistomiasis in Malawi

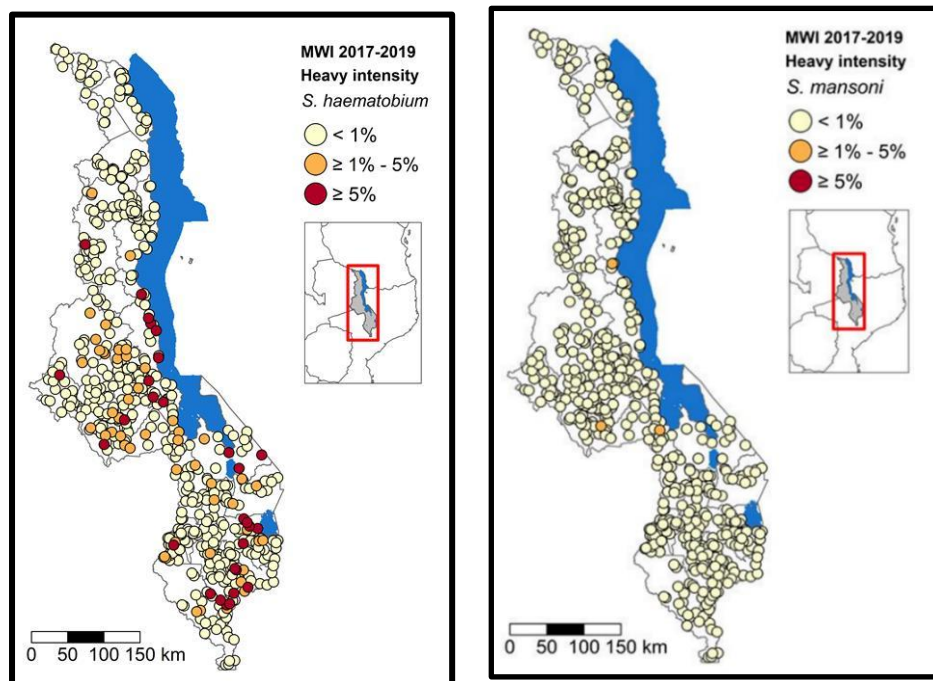
District	Any SCH Prevalence (95% confidence interval)	Year of survey & reference
Mangochi	14.9% (6.9%, 29.3%)	2019, SCIF/MoH Report
Nkhotakota	19.8% (11.7%, 31.4%)	2019, SCIF/MoH Report
Mwanza	7.8% (4.8%, 12.5%)	2019, SCIF/MoH Report
Nkhata Bay	4.0% (1.8%, 8.8%)	2019, SCIF/MoH Report
Salima	4.0% (1.8%, 8.8%)	2019, SCIF/MoH Report
Zomba	17.3% (9.4%, 29.5%)	2019, SCIF/MoH Report
Balaka	2.6% (2.5%, 2.7%)	2018, SCIF/MoH Report
Blantyre	3.5% (3.4%, 3.6%)	2018, SCIF/MoH Report
Chiradzulu	11.7% (11.4%, 11.9%)	2018, SCIF/MoH Report
Lilongwe	3.5% (3.4%, 3.6%)	2018, SCIF/MoH Report
Mzimba North	2.6% (2.5%, 2.7%)	2018, SCIF/MoH Report
Mzimba South	3.1% (3%, 3.3%)	2018, SCIF/MoH Report

Neno	1.9% (1.7%, 2%)	2018, SCIF/MoH Report
Ntcheu	3.0% (2.9%, 3.2%)	2018, SCIF/MoH Report
Ntchisi	3.6% (3.4%, 3.8%)	2018, SCIF/MoH Report
Chikwawa	15.8% (10.9%, 22.4%)	2017, SCIF/MoH Report
Chitipa	4.5% (2.7%, 7.2%)	2017, SCIF/MoH Report
Dedza	13.3% (8.9%, 19.5%)	2017, SCIF/MoH Report
Dowa	1.3% (0.5%, 3.3%)	2017, SCIF/MoH Report
Karonga	4.7% (2.7%, 8.2%)	2017, SCIF/MoH Report
Kasungu	9.3% (6.3%, 13.5%)	2017, SCIF/MoH Report
Machinga	12.4% (9.1%, 16.7%)	2017, SCIF/MoH Report
Mchinji	3.0% (1.7%, 5.3%)	2017, SCIF/MoH Report
Mulanje	13.0% (9.1%, 18.1%)	2017, SCIF/MoH Report
Nsanje	25.4% (15.3%, 38.9%)	2017, SCIF/MoH Report
Phalombe	8.8% (5.6%, 13.7%)	2017, SCIF/MoH Report
Rumphi	1.3% (0.4%, 4.4%)	2017, SCIF/MoH Report
Thyolo	10.4% (6.3%, 16.9%)	2017, SCIF/MoH Report

Urogenital schistosomiasis is caused by *Schistosoma haematobium* while intestinal schistosomiasis is caused by *S. mansoni*. People in communities around water bodies such as lakes, ponds, streams and rivers, get infected through contact with infested water during routine household, recreational, agricultural and income generating activities. These infested water are contaminated with faeces and urine harboring schistosome eggs when people defecate or urinate in these water (Figure 2.2).

As of 2021 Malawi has only reported the existence of two human schistosomes namely *Schistosoma mansoni* and *Schistosoma haematobium*. The disease is transmitted through contact with infected surface water. This particularly affects people engaged in agriculture, fishing and swimming. The prevalence of the disease in the country is estimated between 40% and 50%. School-age children are the highly infected group and represent the most intensely affected. This disease does not only cause immediate morbidity in children but also have long-term effect on their development into adulthood.

Surveys conducted by District Health Offices recently point to the fact that schistosomiasis is a major public health problem in the whole country with prevalence of *S. haematobium* of above 50%.



In Chikwawa district the Bilharzia Laboratory always reports prevalence rates above 80%. All these studies point to the fact that schistosomiasis is wide spread in Malawi, highly prevalent and a major cause of morbidity in the community, particularly school-age children.

Table 5 showing impact of the interventions from the baseline

District	Year of Mapping	Prevalence category	Reassessment
Dowa		ND	Low
Kasungu	Other	High	Low
Nkhosakota	2013	Low	Moderate
Ntchisi	2012	Moderate	Low
Salima	2013	Moderate	Moderate
Dedza	Other	High	Moderate
Lilongwe City	2012	Moderate	Low
Lilongwe Rural East	2012	Moderate	Low
Lilongwe Rural West	2012	Moderate	Low
Mchinji	Other	High	Low
Ntcheu	2012	Moderate	Low
Chitipa	Other	Moderate	Low
Karonga	Other	Moderate	Low
Likoma		ND	Low
Mzimba North	2012	Moderate	Low
Mzimba South	2012	Moderate	Low
Mzuzu City	2012	Low	Low
Nkhata Bay	2013	Moderate	Low
Rumphi		ND	Low
Chiradzulu	2012	Moderate	Moderate
Mulanje	Other	High	Moderate
Phalombe	Other	High	Low
Thyolo	Other	High	Moderate
Balaka	2012	Moderate	Low
Machinga	Other	High	Moderate
Mangochi	2013	Moderate	Moderate
Zomba Rural	2013	Moderate	Moderate
Zomba Urban	2013	Moderate	Moderate
Blantyre City	2012	Moderate	Low
Blantyre Rural	2012	Moderate	Low
Chikwawa		Moderate	Moderate
Mwanza	2012	Moderate	Low
Neno	2012	Moderate	Low
Nsanje	Other	High	Moderate

After the baseline survey the results indicated prevalence of schistosomiasis by districts, and reassessment surveys over the years have showed Significant change in other districts where the category has been changed from low to moderate and others form moderate to low.

Praziquantel, antihelminth drug, is the mainstay treatment for schistosomiasis. Prior to MDA with Praziquantel in 2008, 2009 and 2010, baseline prevalence surveys for *Schistosomiasis haematobium* was carried out in 18 of the 28 political administrative districts in the country and the prevalence ranged from 10% (Mzimba North) to 59.5% (Mulanje). The remaining 10 political districts were surveyed in 2011. Data shows that previously *S. mansoni* was prevalent in the center of the country and *Schistosoma haematobium* very dominant in the South, the 2009-2011 surveys showed that some traditional areas for *Schistoma mansoni* are showing increase in *Schistosoma haematobium* such as Lilongwe and Dedza. Recent studies have shown higher prevalence of *S mansoni* in southern area such as Mangochi (Kayuni et al, 2020).

Soil Transmitted Helminths

Soil-transmitted helminths commonly known as intestinal worms, are the most common infections worldwide, affecting more than 200 million people globally. Risk of infection is higher in areas of poor water, sanitation and hygiene practices where people are poor and do not wear shoes Soil-transmitted helminths are endemic throughout Malawi (Figure 4).

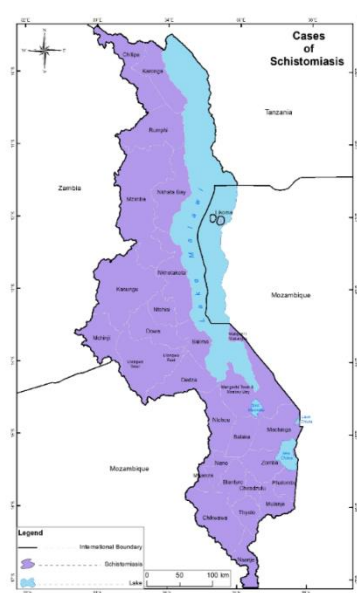


Figure 4. Maps showing endemic districts in Malawi for soil-transmitted helminths.

The success of the control programmes depends on partnerships, community mobilization and capacity building to enhance implementation of the sanitation, health education and chemotherapy efforts.

Ivermectin and albendazole are co-administered. Hence the integrated management of the STH s is beneficial as it reduces number of visits to communities by health personnel, carries out chemotherapy at the same time for all communities hence is cost-effective. The distribution of Ivermectin and Albendazole was done during in the LF MDA and the continuity of that can also help in treating the other intestinal helminths like strongyloides.

TABLE 6: Prevalence Distribution of Soil Transmitted Helminthes in Malawi

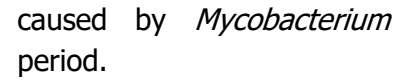
District	Any STH Prevalence	Year of survey & reference
Mangochi	1.1%	2019, SCIF/MoH Report
Nkhotakota	5.9%	2019, SCIF/MoH Report

Mwanza	4.8%	2019, SCIF/MoH Report
Nkhata Bay	0.4%	2019, SCIF/MoH Report
Salima	1.5%	2019, SCIF/MoH Report
Zomba	1.0%	2019, SCIF/MoH Report
Balaka	6.9%	2018, SCIF/MoH Report
Blantyre	2.9%	2018, SCIF/MoH Report
Chiradzulu	6.2%	2018, SCIF/MoH Report
Lilongwe	5.3%	2018, SCIF/MoH Report
Mzimba North	4.5%	2018, SCIF/MoH Report
Mzimba South	4.9%	2018, SCIF/MoH Report
Neno	6.4%	2018, SCIF/MoH Report
Ntcheu	5.0%	2018, SCIF/MoH Report
Ntchisi	8.7%	2018, SCIF/MoH Report
Chikwawa	1.0%	2017, SCIF/MoH Report
Chitipa	14.2%	2017, SCIF/MoH Report
Dedza	0.0%	2017, SCIF/MoH Report
Dowa	1.3%	2017, SCIF/MoH Report
Karonga	0.0%	2017, SCIF/MoH Report
Kasungu	0.2%	2017, SCIF/MoH Report
Machinga	0.7%	2017, SCIF/MoH Report
Mchinji	0.3%	2017, SCIF/MoH Report
Mulanje	11.4%	2017, SCIF/MoH Report
Nsanje	11.3%	2017, SCIF/MoH Report
Phalombe	0.0%	2017, SCIF/MoH Report
Rumphi	0.7%	2017, SCIF/MoH Report
Thyolo	0.6%	2017, SCIF/MoH Report

It is a communicable disease,
leprae with a long incubation
Leprosy is likely

It is considered to be a special because of its permanent consequences such as

Leprosy control is integrated under the clinical services fall under preventive



transmitted by droplets from prolonged and close contact patients. Among the Leprosy remains a leading disabilities. Early detection most important complications and are many negative practices among populations

public health problem
disabilities and social
discrimination and stigma

into the TB programme Division as such it does not directorate as other NTDs.

All countries including Malawi, in the WHO -African region have achieved this elimination target, but of late all countries have been noticing a new trend in increasing numbers of new cases in some districts or pockets. And with the huge numbers of leprosy cases that have been treated there has also been a lot of leprosy disabled persons who need care, and WHO has set up a new target of trying to eliminate leprosy at district level and also to reduce the number of leprosy grade 2 disabilities by 35% basing on 2010 figures.

Leprosy is endemic in all 29 districts in the country and affects all age groups. The disease is very rare in under- five population. Malawi achieved the WHO leprosy elimination target of 1 case per 10,000 population in 1994. Since then the status remains the same (figure 5).

in 2021 Malawi reported 578 new leprosy cases (figure 6). This is a highest number ever reported for the past 10 years and has raised some concern as some districts such as Mchinji, Salima, Dedza, Machinga have reported cases above elimination threshold hence fear of leprosy resurgence.

Control strategies used are early detection and treatment, sensitization of medical staff and communities in endemic areas, disability management and rehabilitation.

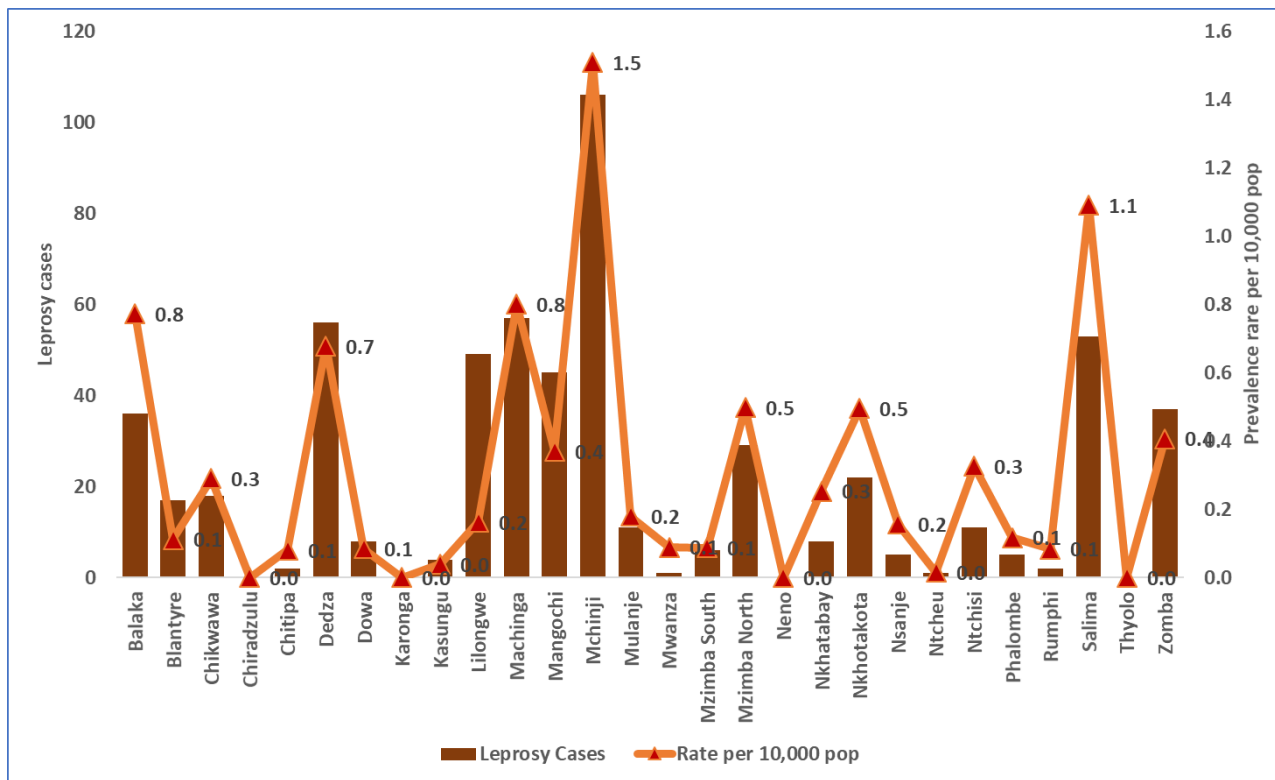


Figure 5: Trends showing endemicity status of Leprosy before 2021

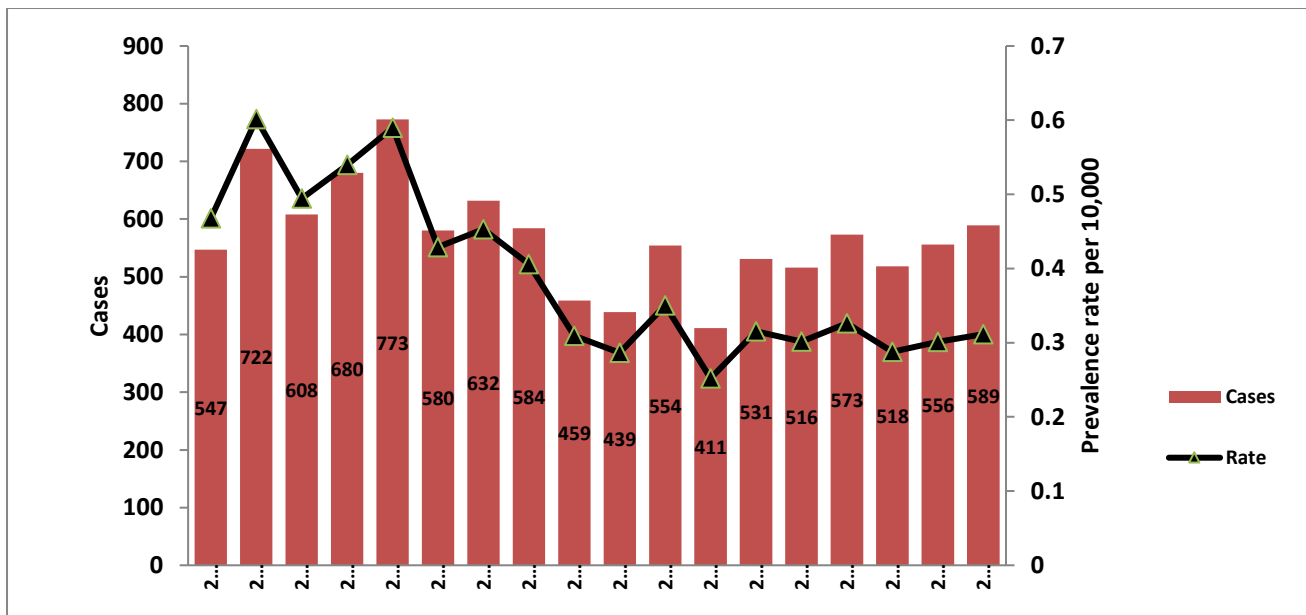


Figure 6: Trends showing new Leprosy cases from 2021

Response: What the Leprosy programme is doing

- Defaulter follow up
- Developing tools to measure other aspects
- Conducting Leprosy supervision to all districts
- Active case finding
- Conduct district new case mapping

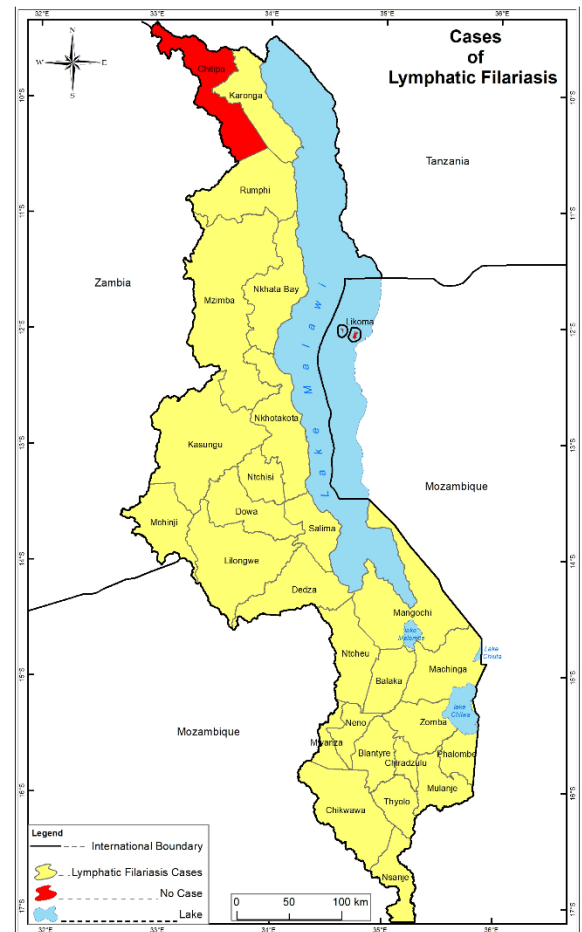
LYMPHATIC FILARIASIS

Lymphatic filariasis, more commonly known as elephantiasis, is a painful and profoundly disfiguring disease. While the disease is usually acquired in childhood its visible manifestations occur in adults leading to temporary and permanent disability. It has a major social and economic impact on endemic countries

Malawi had two previously known LF foci: one in the southern part of the country (Shire valley) and the other in the northern region along the Songwe river which forms its border with Tanzania. Surveys conducted in 2000, in those two foci have reported high antigenaemia prevalence based on immunochromatographic (ICT) card tests. The antigen prevalence approached 80% in some of the sampled villages. There was also remarkably high prevalence of LF associated disease in both areas (4% lymphoedema and up to 18% hydrocele). In addition, the survey in Karonga established that *W. bancrofti* infection was wider spread than previously recognized, whereas in the lower Shire valley a surprisingly high antigenaemia prevalence (55%) was found amongst children (aged 1-9 years) than has been reported anywhere else.

Survey prevalence data by district and village ranged from 0% to 35.9%. In general villages in the western side of the country registered a CFA prevalence of less than 10%. This was with the exception of Mzenge Village in Mchinji District along the Malawi-Zambia border where a prevalence of 18.2% was found. Prevalence of over 20% was observed from villages in Salima and Mangochi districts along the southern shore of Lake Malawi. Also, in Ntcheu district (Bwanje Valley), Balaka district near Lake Malombe and finally in Phalombe district along the shores of lake Chilwa. The highest prevalence (35.9%) was recorded at Kalembo village in Balaka district in southern Malawi. In that survey it was concluded that in Malawi lymphatic filariasis infection is more widespread than previously appreciated. In all districts except Chitipa in the north there was at least one individual who was positive on ICT.

However, 2018 surveillance studies showed prevalence below the minimum threshold for Malawi to declare LF eliminated. As such LF was declared eliminated in 2020.



Section 1.4. Programme Context Analysis

1.4.1. Current NTD Programme Organization and Status

Table 7: National population data, and number of health facilities at District level

Region	Name of District	Population (2018)	Total Area (km ²)	Number of health facilities	Number of Public Primary Schools
Southern	Balaka	438,379	2,142	18	
Southern	Blantyre	1,251,484	2,025	151	
Southern	Chikwawa	564,684	4,878	24	
Southern	Chiradzulu	356,875	761	5	
Southern	Machinga	735,438	3,582	20	
Southern	Mangochi	1,148,611	6,729	35	
Southern	Mulanje	684,107	2,005	27	
Southern	Mwanza	130,949	756	4	
Southern	Nsanje	299,168	1,945	5	
Southern	Thyolo	721,456	1,666	44	
Southern	Phalombe	429,450	1,323	5	
Southern	Zomba	851,737	2,405	31	
Southern	Neno	138,291	1,561	6	
Northern	Chitipa	234,927	4,334	4	
Northern	Karonga	365,028	3,416	15	
Northern	Likoma	14,527	20	2	
Northern	Mzimba	1,157,522	10,619	54	
Northern	Nkhata Bay	285,795	4,182	13	
Northern	Rumphi	229,161	4,560	13	
Central	Dedza	830,512	3,754	19	
Central	Dowa	772,569	3,077	19	
Central	Kasungu	842,953	8,017	27	
Central	Lilongwe	2,626,901	6,211	153	
Central	Mchinji	602,305	3,131	14	
Central	Nkhotakota	395,897	4,338	14	

Central	Ntcheu	659,608	3,251	22	
Central	Ntchisi	317,069	1,709	2	
Central	Salima	478,346	2,151	17	

Table 8: Known disease distribution in Malawi

Region	District	Diseases							
		Preventive Chemotherapy Diseases			Case Management Diseases				
		Oncho	STH	Schisto	LF	Trachoma	HAT	Leprosy	Buruli Ulcer
South	Balaka	0	+	+	+			+	Not Mapped
	Blantyre	+	+	+	+			+	Not Mapped
	Chikwawa	+	+	+	+	+		+	Not Mapped
	Chiradzulu	+	+	+	+			+	Not Mapped
	Machinga	0	+	+	+			+	Not Mapped
	Mangochi	0	+	+	+			+	Not Mapped
	Mulanje	+	+	+	+			+	Not Mapped
	Nsanje	0	+	+	+	+		+	Not Mapped
	Thyolo	+	+	+	+			+	Not Mapped
	Phalombe	+	+	+	+			+	Not Mapped
	Mwanza	+	+	+	+			+	Not Mapped
	Zomba	+	+	+	+			+	Not Mapped
	Neno	+	+	+	+			+	Not Mapped
Centre	Dedza	0	+	+	+			+	Not Mapped
	Dowa	0	+	+	+			+	Not Mapped
	Kasungu	0	+	+	+	+	+	+	Not Mapped
	Likoma	0	+	+	+			+	Not Mapped
	Lilongwe	0	+	+	+	+		+	Not Mapped
	Salima	0	+	+	+	+		+	Not Mapped
	Mchinji	0	+	+	+	+		+	Not Mapped
	Ntchisi	0	+	+	+		+	+	Not Mapped
	Ntcheu	+	+	+	+			+	Not Mapped
North	Mzimba	0	+	+	+		+	+	Not Mapped
	Nkhata Bay	0	+	+	+			+	Not Mapped
	Nkhotakota	0	+	+	+	+	+	+	Not Mapped
	Chitipa	0	+	+	0			+	Not Mapped
	Karonga	0	+	+	+			+	Not Mapped
	Rumphi	0	+	+	+		+	+	Not Mapped

1.4.2 NTD CO-ENDEMICITY IN MALAWI

Nearly all districts have more than one NTD hence co-endemicity of NTDs is very high in Malawi districts

NTD mapping status diseases

The following table summarises the outstanding mapping needs for endemic NTDs in Malawi. Buruli ulcer, Leishmaniasis, require whole country mapping as their status is totally unknown. HAT and schistosomiasis require refining of the distribution and they require additional mapping.

Table 9: NTD mapping status diseases

Endemic NTD	Total # Districts	No. of endemic districts	No. of districts mapped or known endemicity status	No. of districts remaining to be mapped or assessed for endemicity status
LF	29	27	27	0
Oncho	29	10	29	0
STH	29	29	29	0
Trachoma	29	15	29	0
Schisto	29	29	29	0
Leprosy	29	29	29	0
Buruli ulcer	29		Not mapped	29
Leishmaniasis	29		Not mapped	29
HAT	29	5	5	0

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

Vector control

In Malawi, the Vector management or control activities are summarised in table 10. The table indicates the activities and the diseases targeted using vector control interventions

Activity	Table 10. Vectors and Associated NTDs						
	Mosquitoes			Other Vectors			
				Snails	Black fly	Sand fly	Tsetse fly
	LF	Dengue	Malaria	Schisto	Oncho	Leish	HAT
ITN	X	X	X				X
IRS	X	X	X				
Space spraying							
Larviciding	X	X	X		X		
Traps		X	X				X
Prevention/treatment of breeding sites	X	X	X	x	x		X

WASH and NTDS

Safe and sufficient WASH plays a key role in preventing numerous NTDs such as trachoma, soil-transmitted helminths and schistosomiasis. Globally diarrheal deaths as a result of inadequate WASH were reduced by half during the Millennium Development Goal (MDG) period (1990–2015), with the significant progress on water and sanitation provision playing a key role.

CHALLENGES IN WASH

Although 67 per cent of Malawi's households have access to drinking water, distribution among districts, and between urban and rural areas, is uneven. Improved drinking water sources are more common in urban areas at 87 per cent compared to 63 per cent in rural areas. Although people of Malawi have access to clean and potable water, a number of challenges –especially associated with poor practices in transporting and water storage– still remain.

Low access to WASH: Malawi achieved the MDG target for water but 10% of Malawians are still without access to a safe water facility. 10 million people do not have a decent toilet to use. Malawi has registered significant progress in reducing the number of people without access to safe water. In spite of slow progress in the attainment of improved sanitation, remarkable strides have been made in reducing open defecation, from 29% in 1990 to 4% in 2015. Major cities, town centers and rural water

schemes that rely on surface water are increasingly facing huge water supply gaps. There is inadequate forward investment to meet growing population needs in urban areas. At least 25% of water facilities are not functional at any given point in time.

Poor financing for WASH: Approximately 80% of WASH funding comes from donors. Allocation for WASH in the national budget is less than 0.08% of the total budget for 2021/22. The funding focus is so much on water infrastructure development, with no dedicated budget line for sanitation and hygiene interventions. There are no clear and coordinated plans for financing the Sector Investment Plan and the National Sanitation Master Plan. There are no frameworks to quantify contributions from Nongovernmental Organizations (NGOs) and private companies. As a result, there is no full picture of actual investments going to the WASH sector.

Coordination of WASH and NTD partners

There is a Weak sector and cross-sectoral coordination and integration. Sanitation and hygiene lack clear institutional leadership to champion policies, programmes and financing. Mechanisms to coordinate stakeholder efforts in WASH are either weak or non-existent. Efforts to establish a full Sector Wide Approach have been hampered by capacity, leadership and fiduciary challenges. Convening power of the lead Department of Irrigation and Water Development instead of Ministry of Health is compromised by a lack of dedicated resources and limited capacity in the Planning Directorate to foster coordination. Institutional, legal and policy frameworks in the WASH sector present a picture of disintegration and fragmentation, which affects decision making and coordination on critical issues.

The NTD program despite several of the diseases being linked directly to WASH practices for their prevention has no dedicated officers or budgetary allocation for WASH. It has to depend on what stakeholder, who are mainly NGOs for any WASH activity.

Key partners in WASH are WaterAid, UNICEF, Save the Children, World Vision, CHAM.

Pharmacovigilance System

Pharmacovigilance is defined as the science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other drug related problem. The pharmacovigilance of all drugs in the country is carried out in a section of registration under the Pharmacy, Medicines and Regulatory Authority. The purpose of the National pharmacovigilance guidelines is intended for utilization by all health workers at both public and private health facilities.

The goal of the national pharmacovigilance system is to assure the safety of medicines by ensuring reliable and timely exchange of information on drug safety issues. Pharmacovigilance being an arm of patient care aims at making the best use of medicines for the treatment or prevention of disease. The ultimate goal of pharmacovigilance is the rational and safe use of medical drugs, assessment and communication of the risks and benefits of drugs on the market and educating and informing of patients on safety of drugs.

In 2020, National Pharmacovigilance Centre (NPC) was created within the Pharmacy and Medicines Regulatory Authority (PMRA) of Malawi. This centre conducted a variety of activities aimed at institutionalizing pharmacovigilance activities in public health programmes and in hospitals, as well as building capacity of health care providers in reporting adverse drug events.

The NTD Programme in Malawi works in collaboration with pharmacovigilance section. There is a structure in place that works to carry out pharmacovigilance activities in the country. Sentinel sites

exist in selected implementation units, complete with trained contact personnel, and these can provide surveillance of NTDs pharmaceutical commodities in collaboration with specific disease programme officers. These structures however need some capacity building to enable maximum functionality. Stepping up of action on reports made to the pharmacy and poisons' board / division of drug information and pharmacovigilance may also need to be supported.

One Health

One Health is a collaborative approach to health, which recognizes that humans and animals live in a shared environment and there is added value to be gained by working together on issues at the interface of different sectors. The World Health Organization defines One Health as "an approach to designing and implementing programmes, policies, legislation and research in which multiple sectors communicate and work together to achieve better public health outcomes".

Population growth, economic developments and the unprecedented exploitation of the world's finite natural resources are the predominant forces driving the dynamics animal diseases that also afflict human, commonly referred to as zoonotic diseases. Among the neglected tropical diseases that are zoonotic include HAT, schistosomiasis and other soil transmitted helminths. All types of zoonoses are now considered to cause significant health and socio-economic impacts. It is estimated that the 13-top ranked zoonoses are responsible for 2.2 million human deaths and 2.4 billion cases of illnesses every year (Grace et al. 2012). The most visible impacts and challenges of zoonotic infections are due to epidemics and pandemics caused by predominantly new zoonotic pathogens emerging from wild animals. In the first two decades of this century, the world has seen four major pandemics—severe acute respiratory syndrome (SARs), H1N1 influenza A, Zika and the ongoing COVID-19 (Ili 2022).

World Health Organization road map for neglected tropical diseases (NTDs) 2021–2030 recognizes the complexity surrounding control and elimination of diseases of poverty. It emphasizes the need for a paradigm shift from disease-specific interventions to holistic cross-cutting approaches coordinating with adjacent disciplines.

The One Health approach exemplifies this shift, extending beyond a conventional model of zoonotic disease control to consider the interactions of human and animal health systems within their shared environment and the wider social and economic context. This approach can also promote sustainability and resilience within these systems. To achieve the global ambition on NTD elimination and control, political will, along with contextualized innovative scientific strategies, is required (Laing, 2021).

As pointed out Malawi has not been spared these zoonotic conditions as exemplified by having the highest HAT prevalence and case in Africa.

Unfortunately, in Malawi despite the availability of One Health reporting platform between concerned departments of agriculture, water, wildlife and parks and other stakeholders such as NGOs and research institutions; there is no central NTD structure to implement one health concept as this approach requires strong centralized coordination of activities and efforts among various stakeholders.

Snakebite Envenomization

Snakebite is one of the most important NTDs in terms of both incidence and severity, and its clinical characteristics have readily served as a basis for advocacy. Of course, it also occurs in industrialized

countries and even outside the tropics but more than 95% of cases do take place in tropical and/or developing countries.

In 2017, WHO re-categorized snakebite envenomation into the Category A of the Neglected Tropical Diseases. This new situation will allow access to new funding, paving the way for wider and deeper researches. It should also expand the accessibility of antivenoms. Let us hope that it also leads to cooperation among stakeholders, aiming at improving the management of snakebites in developing countries

Malawi is home to at least 66 different types of snakes, of which 11 are considered medically relevant and potentially deadly, while another five species are capable of inflicting extremely painful bites [4].

Malawi's warm temperatures, mountainous forests, and lowlands with humid shrubs and forest covers provide an inviting habitat for snakes. The population's dependence on subsistence farming, wood, and charcoal as a source of energy for cooking makes snake-human interactions common.

Snake antivenom (SAVs) are on the WHO list of essential medicines, they are not part of Malawi's essential medication list within the Essential Health Package. SAV availability is restricted to a few secondary and tertiary level health care facilities across the country and remains erratic 5

Snakebite envenoming remains a public health threat in many African countries, including Malawi. However, there is a shortage of literature on the knowledge of Health Care Workers (HCWs) and the prevalence of snakebite cases in Malawi. The NTD program is to take a leading role in fighting this problem

Mental Health

According to the World Health Organization, NTDs contribute to nearly 1% of the global burden of disease.¹ In fact, more than 1.7 billion people globally require treatment for at least one NTD every year. While in Malawi, no specific study has been undertaken to link with any one NTD.

Global and national implementation of NTD programmes, which have largely been preventive and curative – focusing on addressing physical symptoms through mass administration of medicines for more than a decade – has brought some of these NTDs close to elimination. Despite this, very little has been achieved in morbidity management and the prevention of disabilities due to NTDs. Minimal attention has been paid by development actors to the emotional impact of the conditions on affected persons, thereby limiting early detection of diagnosable mental health conditions associated with NTDs.

There are many common risk factors for mental health conditions and NTDs, such as poverty, being part of excluded groups, and poor access to health care and education, implying a high risk of comorbidity. Most persons with NTDs experience high levels of distress and social exclusion, which impact on their participation in society, including their civil and political rights² and livelihoods – which in turn are recognized determinants of mental ill-health. The resulting emotional consequences of living with an NTD can lead to psychiatric comorbidities, like depression and anxiety, substance abuse and suicide, exacerbating the physical effects of the conditions.

Leaving No One Behind (LNOB)

Leaving no one behind (LNOB) is the central, transformative promise of the 2030 Agenda and its SDGs. This Operational Guide has been developed using the 2030 Agenda's commitment to LNOB at the national level. With the adoption of the 2030 Agenda, UN Member States pledged to ensure “no one will be left behind” and to “endeavour to reach the furthest behind first”.

The summary of intervention information in Malawi as at 2022 is presented in table 11

TABLE 11: SUMMARY OF INTERVENTION INFORMATION ON EXISTING PREVENTIVE CHEMOTHERAPY PROGRAMMES

NTD	Date programme started	Districts targeted	No. of districts covered	Total population in target district (2014)	Population Covered (2014)	Key strategies used
LF	2008	27	27	14,989,401	12,443,745 (83.0%)	MDA
Oncho	1984	8	8	2,183,189	1,810,709 (82.9%)	MDA
Trachoma	2011	7	7	4,695,998		MDA
Schisto	2004	29	29	4,112,215		School & Community treatments
STH	2004	29	29	4,112,215		School treatments
HAT	1996	5	5		100%	Active and Passive Case detection, health facility treatment and Vector Control
Leprosy	1979	29	29		100	Active case finding and health facility treatment
Buruli ulcer	Not started	29	0	0		0
Leishmaniasis	Not started	29	0	0		0

1.5 Building on NTD Programme Strengths

Summarize this information in a table as per example below:



Table 12. SWOT counteracting table

<u>STRENGTHS</u>	<u>WEAKNESSES</u>	<u>OPPORTUNITIES</u>	<u>THREATS</u>
<p>1. Integration within the programs</p> <p>2. Existence of administrative and operational structures at all levels</p> <p>3. Availability of Human resource</p> <p>4. Availability of partners</p> <p>5. Existence of disease specific guidelines</p> <p>6. Availability of procurement and storage system and facilities</p>	<p>1. Absence of centralized NTD programme</p> <p>2. Vertical approach of programme implementation</p> <p>3. Lack of dedicated funding for operational research</p> <p>4. Inadequate domestic funding</p> <p>5. Absence of vector control unit</p> <p>6. Lack of multisectoral collaboration</p> <p>7. Poor disease surveillance</p> <p>8. Absence of centralized record keeping and data management.</p> <p>9. Limited linkage between WASH and NTDs</p> <p>10. Lack of Monitoring mechanisms (Most of NTDs does not appear in DHIS2)</p> <p>11. No mapping for other NTDs</p> <p>12. Inaccessible areas such as Lupachi, Likoma, Lower shire islands</p>	<p>1. Capacity shown and workload reduced by elimination of some NTDs</p> <p>2. Availability of partners who provide technical and financial support</p> <p>3. Availability of other disease programmes also address issues of NTDs and results into cost and resource sharing</p> <p>4. There is Political will to support NTD activities</p> <p>5. Availability of in-country research institutions</p> <p>6. International Obligations such as SDGs</p>	<p>1. Reemergence of other eliminated NTDs</p> <p>2. Natural disasters and emerging diseases e.g. Covid-19 may disrupt NTD activities</p> <p>3. Unpredictable donor support</p> <p>4. Some Human behavioural beliefs affects use of medical facilities and advice</p> <p>5. Climate change is making it conducive for increased NDTs</p> <p>6. Transport and access sometimes can be a challenge</p>

1.5.1. Gaps and priorities

Based on the SWOT Analysis, the major gaps and priorities are itemized (Table 13). Addressing these gaps and focusing on the priorities highlighted will enable Malawi to achieve its strategic goals as reflected in this plan, and eliminate the transmission of some targeted NTDs

Table 13: Gaps and Priorities

Gaps	Priorities
HAT Gaps	Ranked HAT Priorities
1. Lack of dedicated funding for operational research	1. Adequate funding 2. Safe treatment for rHAT 3. Capacity building to manage 4. rHAT Adequate Disease surveillance 5. rHAT data to be captured in the DHIS2 6. Establish a robust vector control system 7. Community mobilization and empowerment
ONCHO Gaps	ONCHO Priorities (ranking required)
1. Lack of dedicated funding for operational research 2. Inadequate domestic funding 3. Absence of vector control unit 4. Lack of multisectoral collaboration 5. Poor disease surveillance 6. Oncho data is not captured in the DHIS2 7. Absence of cross boarder meeting	1. to have Adequate funding 2. disease surveillance 3. Oncho data to be captured in the DHIS2 4. vector control unit 5. Capacity building to manage Oncho dermatitis
TRACHOMA GAPS	Trachoma Priorities (Ranked)
1. No direct funding from government side. 2. Lack of dedicated funding for operational research 3. Weaknesses in disease surveillance 4. Lack of Monitoring mechanisms 5. Absence of NTD programme	1. Adequate funding from the government. 2. Provide capacity building to OCOs for better management of trachoma cases. 3. Provide resource for routine disease surveillance 4. Devise workable monitoring mechanisms strategy. 5. Dedicate funding for operational research
Schisto and STH Gaps	
1. There is inadequate Funding 2. There is no Operational research 3. There are no vector control activities 4. Data capturing and management is inadequate 5. Diagnostics require strengthening (capacity, personnel + tools) 6. Surveillance requires strengthening (Vector mapping, Disease type mapping) 7. Lack of national NTD program 8. Inadequate community awareness for STH 9. Lack of dedicated donor/partner for STH	
Leprosy Gaps	Leprosy Priorities (ranking required)

<ol style="list-style-type: none"> 1. Inadequate domestic funding 2. Lack of multisectoral collaboration 3. Poor disease surveillance 4. Lack of dedicated funding for operational research 5. Knowledge gap to diagnose Leprosy conditions 6. Lack of Leprosy disease specific guidelines 7. Parallel supply chain system not integrated into the current PSM system 	<ol style="list-style-type: none"> 1. To integrate supply chain system into the current PSM system
LF Gaps	LF Priorities (ranked)
<ol style="list-style-type: none"> 1. Inadequate domestic funding 2. Poor disease surveillance 3. Lack of multisectoral collaboration 4. Lack of dedicated funding for operational research 	<ol style="list-style-type: none"> 1. Getting adequate domestic funding 2. Enough medical and surgical supplies 3. disease surveillance 4. adequate skilled personnel 5. community sensitization and engagement 6. community sensitization and engagement

PART 2

Strategic Agenda:

Purpose and Goals

The Malawi NTD Master Plan, which is a seven-year strategic plan (2023-2030), includes Mission, Vision, Guiding principles, Programme Strategic Priorities and Pillars.

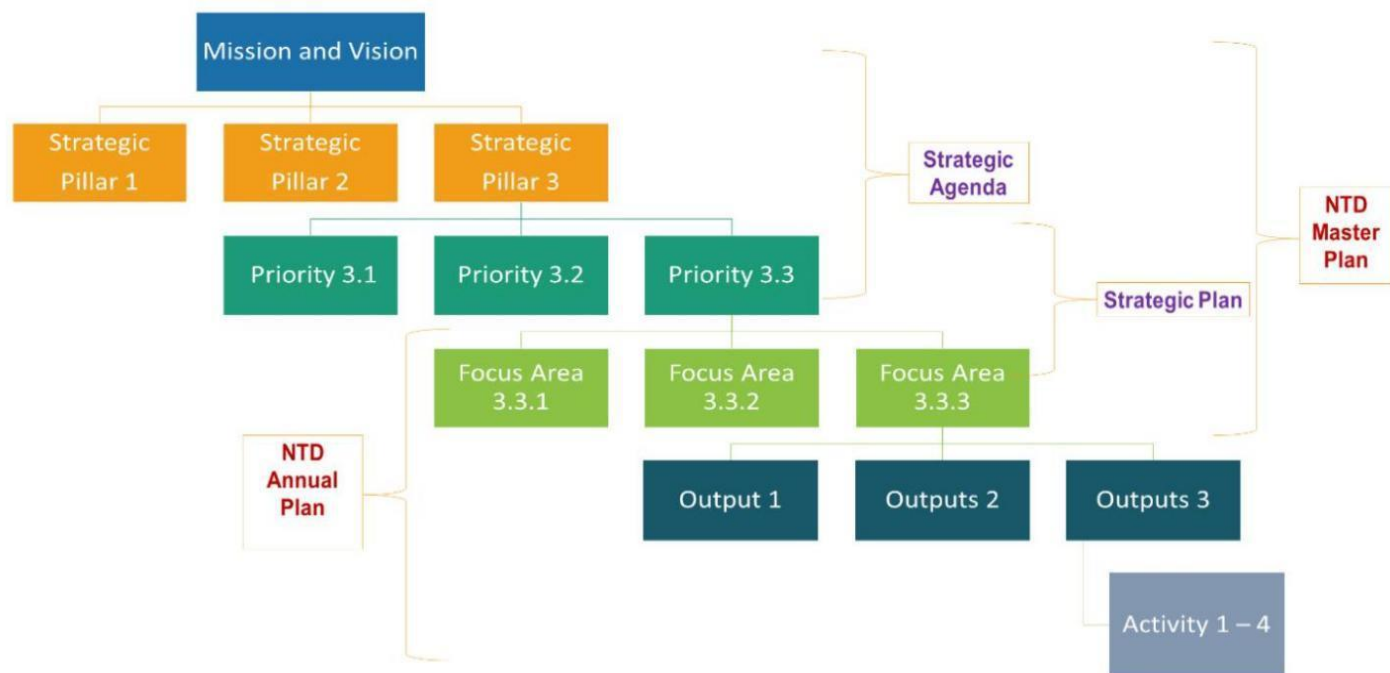


Figure 7: Hierarchy of Objectives for Malawi NTD programmes

Section 2.1: NTD Program Mission and Vision

Table 14. Mission and vision	
Mission <i>What we exist to do</i>	To improve the health status of all the people of Malawi by eliminating all targeted NTDs
Vision <i>Where we need to go</i>	A Malawi free from NTDs by 2030

Section 2.2: Milestones and Targets

TABLE 15: MILESTONES FOR HUMAN AFRICAN TRYPANOSOMIASIS

Indicators	2023	2024	2025	2026	2027	2028	2029	2030
To make sure areas requiring programme attention are covered	60%	65%	80%	80%	100%	100%	100%	100%
To ensure that programmatic activities are carried out timely and consistently	60%	65%	80%	80%	100%	100%	100%	100%
To achieve optimal utilization of resources and gains through collaborative approach (one health)	60%	65%	80%	80%	100%	100%	100%	100%
For data to be readily available and accessible for evidenced based decision making	60%	65%	80%	80%	100%	100%	100%	100%
To ensure that rHAT is no longer a disease of public importance in 5 active transmission districts	60%	65%	80%	80%	100%	100%	100%	100%
To ensure that there is coordination and deployment of intervention at all levels	60%	65%	80%	80%	100%	100%	100%	100%
To ensure integration of rHAT management into routine health services delivery	60%	65%	80%	80%	100%	100%	100%	100%

TABLE 16: MILESTONES FOR ONCHOCERCIASIS

Milestones for Onchocerciasis								
Indicators	2023	2024	2025	2026	2027	2028	2029	2030
Sustain MDA in two districts from 2023	100%	100%	100%	100%	100%	100%	100%	100%
Stopping MDA in 60 % of the endemic districts (Neno, Chikwawa, Blantyre and Mwanza) (2026)	100%	100%	100%	100%	100%	100%	100%	100%
Stopping MDA in all endemic districts (2027)	100%	100%	100%	100%	100%	100%	100%	100%
To have no active disease in the population (2027)	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 17: MILESTONES FOR TRACHOMA

Indicators	2023	2024	2025	2026	2027	2028	2029	2030
Sustain a national prevalence of less than 5% TF.	100%	100%	100%	100%	100%	100%	100%	100%
Ensure that all cases are taken care of even after certification.	100%	100%	100%	100%	100%	100%	100%	100%
Ensure that all districts have capacity to detect and manage trachoma.	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 18: MILESTONES FOR LYMPHATIC FILARIASIS

Indicators	2023	2024	2025	2026	2027	2028	2029	2030
Determine vector infectivity status in all districts	50%	60%	70%	80%	90%	100%	100%	100%
Maintaining elimination status of less than 1%	100%	100%	100%	100%	100%	100%	100%	100%
50% of lymphoedema cases are provided with basic care (sanitary materials & analgesics)	100%	100%	100%	100%	100%	100%	100%	100%
Existing population of persons with hydrocele are reduced by 50% through surgeries	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 19: MILESTONES FOR LEPROSY

Indicators	2023	2024	2025	2026	2027	2028	2029	2030
To develop and disseminate Malawi national specific leprosy guidelines (diagnostic and management)	100%	100%	100%	100%	100%	100%	100%	100%
Decentralize/ strengthen leprosy services to all districts	100%	100%	100%	100%	100%	100%	100%	100%
Have an active national surveillance in place	100%	100%	100%	100%	100%	100%	100%	100%
Train HCWs at all levels	100%	100%	100%					
To have leprosy impact indicators in place	100%	100%	100%	100%	100%	100%	100%	100%
To have a nation with good knowledge about leprosy	100%	100%	100%	100%	100%	100%	100%	100%
To have 95% leprosy drug availability across facilities	100%	100%	100%	100%	100%	100%	100%	100%

Table 20: MILESTONES FOR SOIL TRANSMITTED HELMINTHS

	INDICATORS	2023	2024	2025	2026	2027	2028	2029	2030
1	Sustain school-based/community-based treatments in Endemic Districts	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
2	Sustain 100% geographical treatment coverage in STH Endemic Districts	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
3	Sustain minimum of 75% Therapeutic coverage in STH endemic Districts	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
4	Conduct mid-term assessment activities in at least 50% of STH Endemic Districts after at least 3 years of consecutive treatments	10 (34%)	15 (50%)	25 (85%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
5	Endemic Districts achieving moderate morbidity control (WHO intensity grading)	10 (34%)	15 (50%)	25 (85%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
6	Endemic Districts achieving advanced morbidity control (WHO intensity grading)	10 (34%)	15 (50%)	25 (85%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
7	Proportion of Districts with Basic WASH	10 (34%)	15 (50%)	25 (85%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
8	Proportion of Districts achieving Open Defecation Free	10 (34%)	15 (50%)	25 (85%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
9	Endemic Districts achieving elimination of transmission		15 (50%)	25 (85%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)

TABLE 21: MILESTONES FOR SCHISTOSOMIASIS

Indicators	2023	2024	2025	2026	2027	2028	2029	2030
Sustain SCH MDA in IUs requiring SCH MDA	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
Sustain Geographical treatment coverage in SCH endemic districts	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
Percentage of low endemic IUs that conducted more than 3 rounds of with coverage more than 75%	15 (50%)	20 (60%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
Percentage of moderate - highly endemic IUs conducted more than 5 rounds of with coverage more than 75%	15 (50%)	20 (60%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
Number of IUs with full coverage of WASH interventions.	15 (50%)	20 (60%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
Percentage of IUs conducted first impact assessment at least 3 rounds of MDA.	15 (50%)	20 (60%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)
Number of IUs conducted first impact assessment at least 5 rounds of MDA.	15 (50%)	20 (60%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)	29 (100%)

2.2.1 Overarching Targets

Table 22. Overarching targets for the country with a 2030 timeline

By 2030, Malawi will achieve the following:	
<ul style="list-style-type: none">• About 100% reduction in people requiring interventions against NTDs• About 75% reduction in disability-adjusted life years related to NTDs• Reduce by 100% the number of people requiring treatment for NTDs• Eliminate Onchocerciasis in all endemic districts• Sustain the elimination momentum of Trachoma, Leprosy and Lymphatic Filariasis towards Eradication• Disease specific targets that include a reduction by more than 75% in the number of deaths from vector borne NTDs• Promote full access to basic water supply, sanitation, and hygiene in areas endemic for NTDs.• Achieve greater improvement in collecting and reporting NTD data disaggregated by demographic variables	

2.2.2 Cross Cutting Targets

Table 23. Cross-cutting targets for the country with a 2030 timeline

Cross Cutting Areas	Targets
Integrated Approaches	<ul style="list-style-type: none">• Sustain 75% of integrated treatment coverage index for preventive chemotherapy (Onchocerciasis, SCH, STH)• Adopt and implement integrated skin NTDs strategies in 29 Districts• Achieve 75% reduction in number of deaths from vector-borne NTDs to achieve WHO's global vector control response goal
Multisectoral Collaboration	<ul style="list-style-type: none">• Achieve 80% access to at least basic water supply, sanitation and hygiene in areas endemic for NTDs
Country Ownership	<ul style="list-style-type: none">• All Districts reporting on all relevant endemic NTDs• All Districts reporting demographic disaggregated data on relevant endemic NTDs
Universal Coverage	<ul style="list-style-type: none">• All 29 Districts include NTDs in their package of essential services and budgeting• All 29 Districts use national guidelines for management of NTD-related disabilities within the national health systems

2.2.3 Disease Specific Targets

Table 24. Disease-Specific Targets

HAT Specific targets

National target	Diseases	Objective	Year	Strategies
To make sure all areas requiring programme attention are covered	rHAT	To ensure adequate resources for surveillance and mapping	2023	lobbying
To ensure that programmatic activities are carried out timely and consistently	rHAT	To secure stable budget lines for specific activities	2024	Activity based budget planning
To achieve optimal utilization of resource and gains through collaborative approach (one health)	rHAT	To ensure multisectoral approach to eliminate HAT in Malawi	2024	Taking advantage of DIP development activities
For data to be readily available and accessible for evidenced based decision making	rHAT	To ensure that impact indicators to be used in DHIS 2 are in place	2023	Identify indicators to be captured in DHIS2
To ensure that rHAT is no longer a disease of public importance in 5 active transmission districts	rHAT	To eliminate rHAT	2030	Increased and improved surveillance
To ensure that there is coordination and deployment of intervention at all levels	rHAT	To ensure that adequate personnel is available for all positions and tasks	2026	Recruitment and deployment
To ensure integration of rHAT management into routine health services delivery	rHAT	To make sure relevant skills are available for successful operation of tasks	2026	In service training

Oncho-Specific Targets

National target	Objective	Year	Strategies
Stopping MDA in 60% of the endemic districts (Neno, Chikwawa, Blantyre, Phalombe, Chiradzulu and Mwanza)	To eliminate as a disease of public health importance in 90% of endemic districts	2024	Efficient MDA coverage EPI survey and Ento survey
Stopping MDA in all endemic districts	To eliminate as a disease of public health importance	2030	Efficient MDA coverage EPI survey and Ento survey
Elimination of Oncho in all districts	To eliminate as a disease of public health importance	2030	Efficient MDA coverage EPI survey and Ento survey
All districts verified for interruption transmission	To eliminate as a disease of public health importance	2030	EPI survey and Ento survey
Introduce MDA in two districts	To eliminate as a disease of public health importance	2023	Efficient MDA coverage
To have no active disease in the population	To have no individual still suffering from Oncho	2030	Survey to identify cases Training of health workers in case management

SCHISTO/STH -SPECIFIC TARGETS

National target	Diseases	Objective	Year	Strategies
Targeted for elimination as a public Health problem	Schisto/STH	To reduce prevalence of schistosomiasis and STH to a level of no public health importance by 2030	2026	1. MDA 2. Diagnosis and treatment 3. BCC 4. WASH 5. Vector control

TRACHOMA-SPECIFIC TARGETS

National target	Objective	Year	Strategies
Sustain national prevalence of less than 5% TF.	1. To achieve timely certification of trachoma elimination in Malawi.	2023	Efficient management of walk in cases Documentation
Sustain programme decisions based on evidence.	2.To ensure that all indicators are Impact based and not operational	2023	To have review meeting on indicators
To ensure that all cases are taken care of even after certification.	3.To ensure that trachoma is integrated into routine eye care.	2023	Capacity building and supportive supervision
To ensure that all districts have capacity to detect and manage trachoma.	4.To ensure that adequate personnel is available for all positions and tasks	2023	Capacity building and supportive supervision

Section 2.3: Guiding Principles

Table 25. Guiding principles	
Guiding principles	<ul style="list-style-type: none">• 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 for NTD programme to be successful. The below figures are Malawi programme strategic pillars.

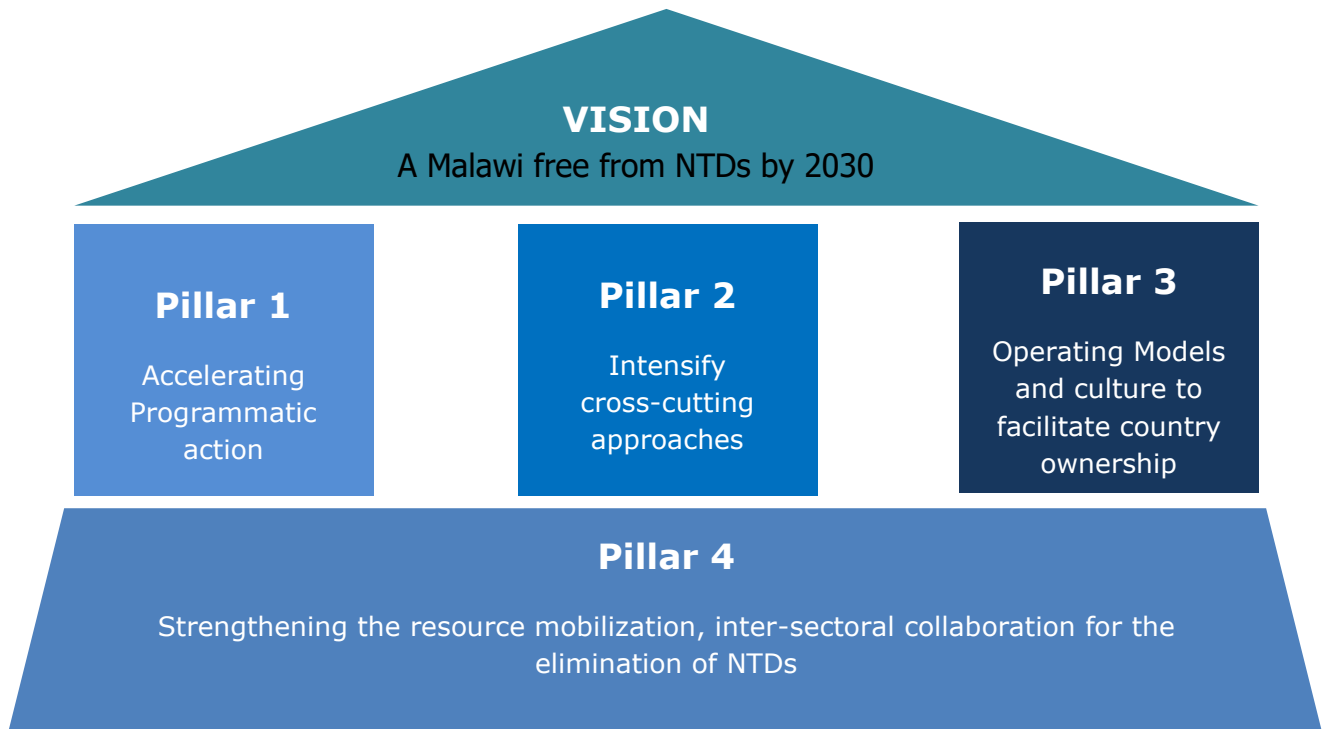


Figure 8: Programme Strategic Pillars

2.4.2. Strategic Priorities

Table 26. Strategic Priorities for the Elimination of Neglected Tropical Diseases

Examples of Strategic Pillar	Examples of priorities
Pillar 1. Accelerating programmatic action	Scale up integrated preventive chemotherapy to achieve 100% geographic and treatment coverage to Onchocerciasis.
	Prioritize and strengthen monitoring and evaluation to track progress and decision making towards the 2030 goals
	Ensure timely, safe, and effective supply chain management of quality-assured NTD Medicines and other products up to the last mile
Pillar 2. Intensify cross-cutting approaches	Strengthen identified platforms with similar delivery strategies and interventions (MDAs, skin NTDs, Morbidity management, WASH, One Health, etc) for integrated approaches across NTDs
	Mainstream delivery platforms within the national health system
	Integrate safety across NTD planning, implementation, and monitoring
Pillar 3. Operating Models and culture to facilitate country ownership	Promote and strengthen country ownership and leadership through organizational structures at national and districts with dedicated funding
	Empower districts authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions
Pillar 4. Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs	<p>Promote community involvement and ownership of the program for optimal use of available resources</p> <p>Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.</p>

2.3 Program Strategic Agenda Logic Map

Figure 9 below provides a logic frame upon which the Malawi NTD program will work and its inter-relatedness.

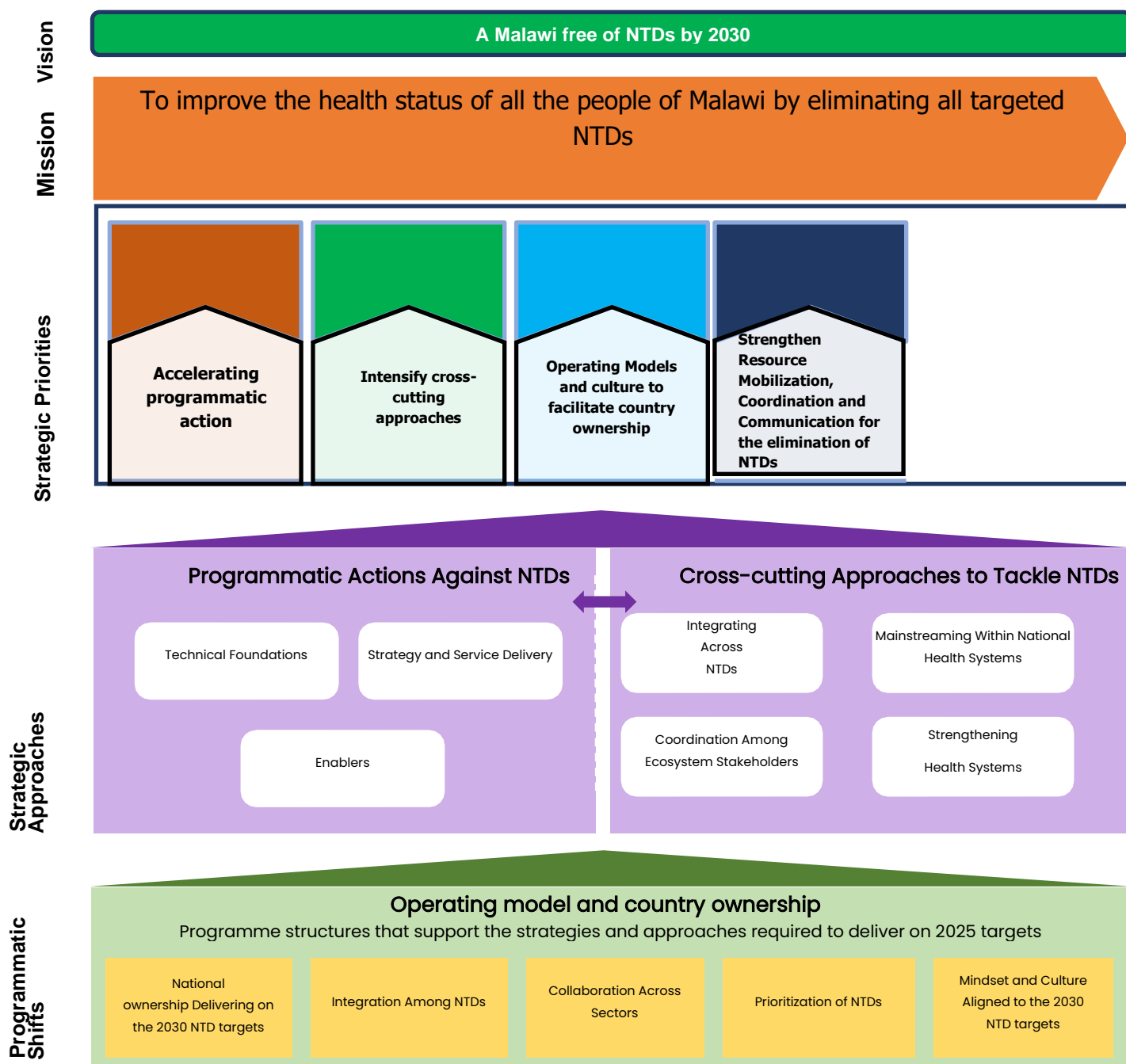


Figure 9: Program Strategic Agenda Logic Map of Malawi NTD Master Plan

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 in Malawi.

Section 3.1: Strategic priorities and Key Activities

Strategic Pillar 1 - Accelerating Programmatic Actions

Table 27: Strategic Pillar 1 - Accelerating Programmatic Actions

Strategic Priorities	Activities	Resources needed	Timeframe	Action by
Establishment of the NTD program	1.To ensure that all NTDs are under one secretariat 2.Ensure coordination and linkage among NTDs	Human resource, Funding, Logistics, Medical products, IEC materials, Office space	2023 - 2023	MOH, Partners
Availability of Required Human capacity	1.To make sure relevant skills are available for successful operation of tasks 2. To ensure that adequate personnel is available for all positions and tasks	Human resource, Meeting Hall, Funding, Logistics	2023-2029	MOH, Partners
Adequate and consistent funding	1.To achieve timely execution of activities 2.To ensure adequate resources for surveillance and mapping 3. To secure stable budget lines for specific activities	Human resource, Meeting Hall, Funding, Logistics, Tools, IEC materials	2023-2029	Community, Districts, MOH, Partners

	3. MDA supervision	Human resource, Funding, Logistics, Tools, Medicines	2023-2030	Community, Districts, MOH, Partners
	4. Collection and collation of data and reverse logistic	Human resource, Communication, Funding, Logistics, Tools	2023-2030	Community, Districts, MOH, Partners
Scale up integrated case management based disease intervention for IDMs (Leprosy, Mental Health and disability)	Integrated training of all relevant stakeholders in endemic areas	Human resource, Meeting Hall, Funding, Logistics, Tools, IEC materials	2023 - 2029	Districts, MOH, Partners
Scale up backlog of TT surgeries (Trachoma)	1. Conduct of case finding and management of trichiasis cases in all endemic communities.	Human resource, Tool kits, Medical products, Funding, Logistics, Communication	2023 -2025	Districts, MOH, Partners
	2. Capacity Building of TT surgeons and Team	Human resource, Meeting Hall, Funding, Logistics, Tools, IEC materials	2023 -2025	Districts, MOH, Partners
Scale up implementation activities in the areas of assessment and surveillances	1. Conduct Epidemiological, Entomological and elimination mapping for onchocerciasis in all relevant transmission zones	Medical products, Human resource, Logistics, Funding	2023 - 2030	Communities, Districts, MOH, Partners
	2. Conduct all outstanding Pre-TAS and TAS surveys in	Medical products, Human resource, Logistics,	2023 - 2027	Communities, Districts, MOH, Partners

	relevant implementation units	Funding		
	4. Conduct Impact assessment in all Implementation units that have conducted 5 effective round of treatment of Schisto and/or STH	Medical products, Human resource, Logistics, Funding	2023 - 2029	Communities, Districts, MOH, Partners
Finalize Impact Assessment Guideline for Schisto/STH	Hold meetings to review and Finalize the draft impact assessment guideline	Human resource, Meeting Hall, Funding, Logistics, Tools, IEC materials	Q3 2023	MoH, Partners
Assess the burden of schisto	Mapping in the 29 Districts to include disease types, female Genital Schistosomiasis (FGS), hybrid schisto in Malawi, etc	Human resource, Protocol/Tools, Funding, Logistics, Communication	2023 - 2024	Districts, MOH, Partners
	2. Capacity Building of health workers and community members for Case Detection	Human resource, Protocols, Funding, Medical products	2024 - 2027	Districts, MOH, Partners

	of FGS (e.g TBAs)			
	3. Capacity building of Traditional birth attendants in endemic districts	Funding, guidelines, Human resources	2024 -2027	MOH, Partners
Reduction and control of snail intermediate host in infested water bodies within endemic communities	1. Establish a snail intermediate host control Laboratory for vector Identification and management	Human resource, Funding	2025	MOH, Partners
	2. Establish Partnerships with research institution to accelerate trials of new innovative technologies for rapid diagnosis	Human resources, Funding, Advocacy tools	2023 -2025	MOH, Partners
Reduction and control of miracidia and cercaria in infested water bodies	Lavicing of water bodies within Schistosomiasis endemic communities	Human resources. Funding, Logistics, Tools and capacity	2023 -2027	Districts, MOH, Partners
Set up of program/case specific TWGs	Establishment of Monitoring and Evaluation (M and E), ACSM, WASH, LF	Human resource, Communication	Q2 2023	MOH, Partners
	Establishment of TWG in preparation for dossier	Human resource, Communication	Q2 2023	MOH, Partners

	preparation			
Programme Coordination	Conduct bi-annual TWGs for Oncho, LF, Trachoma, Schisto, STH, M and E, WASH,	Human resource, Meeting Hall, Funding, Logistics, Tools, IEC materials	2023 - 2030	MOH, Partners
	Biannual TWG meetings for Monitoring and Evaluation, WASH, LF and Trachoma	Human resource, Meeting Hall, Funding, Logistics, Tools, IEC materials	2023 - 2030	MOH, Partners
	Conduct annual Dossier preparation TWGs for Qualifying NTDs	Human resource, Meeting Hall, Funding, Logistics, Tools, IEC materials	2027 - 2030	MOH, Partners

Part 3: Section 2 (Strategic Pillar 2 - Intensify cross-cutting approaches)

Intensify Cross-cutting approaches

Develop Policy guidelines and SOPs to accelerate MDA and other implementation activities for all NTDs	1.Hold meetings to finalize draft policy documents	Human resource, Funding, TWG Honorarium, Meeting Hall, Logistics	Q2 to Q3 2023	MOH, Partners, TWG
	2. Distribution of policy documents and SOPs to Districts	Logistics and Communication	Q3 2023	MoH
Develop integrated NTD Master Plan	Hold meetings for finalization of documents at National and	Human resources, Funding, Meeting hall, Reference	Q1 2023	Districts, MOH, Partners

at National and District levels	District levels	Documents		
Capacity Building	1. Capacity Building on the use of Score card for accountability and tracking of progress	Human resources, Funding, Meeting hall, Tools	2023 - 2025	MOH, Partners
	2. Refresher Training on DHIS2 for National officers, and trainings at District level for outstanding districts	Human resources, Funding, Meeting hall, Tools	2023 - 2025	Districts, MOH, Partners
	3. Training on Supervisors coverage tool for district officers	Human resources, Funding, Meeting hall, Tools	2023 - 2025	Districts, MoH, Partners
	4. Capacity building on Geographic information system for National and District officers	Human resources, Funding, Meeting hall, Tools	2023 - 2024	Districts, MOH, Partners
	5. Capacity Building of National officers on Data analytics and predictive model	Human resources, Funding, Meeting hall, Tools	2023 - 2025	MOH, Partners
Cross cutting Coordination	1. Collection, collation, review and validation of annual technical	Human resource, Communication	1 st Qtr of 2024 - 2027	Districts, MoH, Partners

	reports, treatment and training data for 29 Districts			
	2. Meeting for the Completion of Final NTD Annual Technical Report annually	Human resource, Meeting Hall, Communication, State Reports, Logistics	Q2 of 2024 - 2027	MOH
	3. Conduct annual NTD Steering Committee meeting	Human resources, Funding, Meeting hall, Tools, Logistics, Communication	Q1 and Q4 2024 - 2027	MOH, Partners
	4. Half-yearly NTD Review Meetings (National, Districts, Validation meetings with partners)	Human resources, Funding, Meeting hall, Tools, Logistics, Communication	2024 - 2027	Districts, MOH, Partners
	5. Cross Border Collaboration with Tanzania, Zambia and Mozambique (Meetings, Monitoring and Supervision)	Human resources, Funding, Meeting hall, Tools, Logistics, Communication	Annually, 2024 - 2027	Districts, MOH, Partners
Scale up integrated Preventive Chemotherapy (PC) packages to achieve	1. Integrated Capacity building of implementers at all levels	Human resource, Medicines Logistics, training hall, Reporting tools	2023 - 2027	Communities, Health workers, Districts, Partners
	2. Conduct integrated MDA	Medicines, Human resource,	2023-2027	Communities, Health workers,

100% geographic coverage and treatment access for all NTDs	in all endemic Districts for PC NTDs.	Logistics, training hall, Community registers		Districts, Partners
	3. MDA supervision		2023-2027	Districts, MOH, Partners
Post Treatment Surveillance	1. Finalization of Post Elimination Surveillance (PES) plans including approved IEC materials, plans for immigrants and Internally displaced persons in view of Onchocerciasis and Lymphatic Filariasis elimination in the districts	Human resource, IEC materials, Medicines	Q1 to Q3 2024 to 2025	MOH, Partners
	2. Conduct post treatment surveillance activities in Districts (mobilization and sensitization, entomological evaluation, IEC materials, Meetings)	Hall, DSA, Transportation, Stationeries, Communication, Feeding, Banners, IEC materials, Survey consumables	2024 - 2027	MoH, District Health Officers, Partners, Communities
Review of Integrated NTD Supervisory checklist	Capacity Building on the use of supervisory checklist at all	Funding, Human resource, Meeting hall	2024 -2027	Districts, MoH and Partners

for NTD Supervision	levels			
Coverage Evaluation Survey of PC NTDs	Conduct surveys in NTD endemic areas of 29 Districts	Human resource, Logistics, IEC materials, tools, Funding	2024 - 2027	Districts, MoH and Partners
Scale up of DHIS2 in the progression to transition from paper-based to electronic data collection of all PC-NTDs in 29 Districts	1. Training of Districts on DHIS2	Human resource, Meeting Hall, Logistics, IEC materials, Reporting tools, Funding	2024 - 2027	Districts, MoH and Partners
	2. Establishment of DHIS2 command center	Human resource, Meeting Hall, Logistics, Funding, Communication	2024 - 2027	Districts, MoH and Partners
	3. DHIS2 Data reporting	Human resource, Logistics, Funding, Communication	2024 - 2027	Districts, MoH and Partners
Data Quality Assessment	Conduct DQA in 29 Districts	Human resource, Logistics, IEC materials, tools, Funding	2024 - 2027	Districts, MoH and Partners
Score Card Assessment	Use of the scorecard for accountability and tracking of implementation activities	Human resource, Tools	2024 - 2027	Districts, MOH. Partners
Establishment of a WASH-NTD Coordination office	1. Assign Desk officer and Supporting Staff	Human resource	Q1 2024	MOH, Partners
	2. Equip office	Office equipment	Q1 2024	Partners MOH, Partners
	3. Capacity Building for WASH-NTD officers	Human resource, Funding, Meeting Hall	2024 - 2027	

	4. Collation and update on all WASH-NTD related data		2024 - 2027	MOH
	5. Hold meeting with WASH agencies and line ministries to merge WASH - NTD data	Human resource, Funding, Meeting Hall, logistics	2024 - 2027	MOH, Partners
	6. Advocacy to Water agencies and UNICEF to prioritize communities with high burden of WASH related NTDs in provision of boreholes and toilet facilities	Human resource, logistics	2023 - 2027	MOH, Partners
Scale up use of newly created reporting platform for WASH-NTD Merge	1. Capacity building on the use of WASH-NTD merge at all levels	Funding, tools, Human resources	2023 - 2024	MOH, Partners
	2. Scale up on the use of the platform by all districts	Funding, advocacy tools, Human resources	2024 -2027	Districts, MOH, Partners
	3. Update and validation of data on the platform	Human resource	Q2 and Q4 2024 - 2027	MoH
	4. Development of guideline on use of the WASH-NTD merge	Human resource, Funding, Meeting Hall, TWG	Q2 2023	
Data Collection	1. Stakeholders meeting to	Human resource, Funding, Meeting	Q4 2023	MOH, Partners

for CM-NTDs	agree on key indicators for CM-NTDs data collection tool	Hall, Logistics, Communication		
	2. Development of integrated CM-NTD reporting data collection tool	Consultant fee, Human resource	Q1 2024	Consultant, MOH
	3. Field testing of newly developed NTD tools	Human resource, Funding, Logistics, Tools	Q3 2024	Districts, MOH, Partners
	4. Supervision on the use of the tools	Human resource	2025 - 2027	MOH, Partners
	5. Collection, Collation and Validation of all district Data at National level	Human resource	2025 - 2027	MOH
Strengthen logistic management system of CM-NTDs (cold chain facilities, Leprosy medicines, FGS)	1. Provision of cold chain system (vaccines carriers, ice pack)	Funding, Logistics	2023 - 2027	Districts, MOH, Partners
Harmonize data collection tools for IDMs to facilitate integration into the HMIS	2. Distribution of vaccines	Human resources	2023 -2027	Districts, MOH, Partners

system				
Streamline an integrated CM-NTDs into the National HMIS	Conduct meetings with relevant stakeholders	Human resource, Funding, Meeting hall, Tools	2024	Districts, MOH, Partners

Strategic Pillar 3: Operating models and culture to facilitate country ownership

Promote community ownership	1. Strengthen Community Self-Monitoring (CSM) and follow up on reports of CSM	Human resource, Tools	2023 -2027	Communities, Districts, Partners
	2. Involve community based organizations in programme implementation and monitoring	Human resource	2023 -2027	Communities, Districts, Partners
	3. Mobilization of communities for effective community engagement and ownership (Town announcers, Jingles, Talk shows, Town Hall meeting)	IEC materials, Transportation, Funding, Allowances, Human resource, Public address system	2023 - 2027	Communities, Districts, Partners
	4. Advocacy to Civil Society Organizations that could influence/advocate for government commitment to IDMs	Human resource, Logistics, Communication , Tools	2023 - 2025	Communities, Districts, MOH, Partners
Establish a sustainable community reward system for best performing community in MDA and other	Presentation of awards during stakeholders meeting to community implementers for impressive performance in MDA implementation to	Funding	2023 - 2027	Communities, Districts, MOH, Partners

interventions .	foster sustainability			
Strengthen government ownership of projects	1. Conduct high level advocacy to government officials, private companies and National and International organizations for counterpart funding as well as provision of enabling environment for programme implementation	Human resource, Meeting Hall, Logistics, Communication , IEC materials, Advocacy Tools	2023 - 2027	MoH, Partners
	2.Development and Production of IEC materials	Human resource, Meeting Hall, Logistics, Communication	2023 - 2027	MoH, Partners
	3. Develop plans to aid sensitization of new leaders.	Human resource	2023 - 2025	Districts, MOH, Partners
Strengthen and foster partnerships for CM-NTDs at all levels.	Conduct Bi - annual meeting for sensitization of stakeholders on case management NTDs	Human resource, Meeting Hall, Logistics, Communication , IEC materials, Advocacy Tools	2023 - 2027	MoH, Partners
Strengthen Advocacy, Communicati	1. Provide human resource and equipment	Human resource, Funding, Office	Q1 2024	MOH, Partners

on and Social Mobilization (ACSM) unit		equipment		
	2. Build capacity of ACSM personnel	Human resource, Funding, Meeting Hall	Q1 2024	MOH, Partners
	3. Development of NTD - ACSM Guideline	Human resource, Funding, Meeting Hall, Consultant	Q4 2023	MOH, Partners, Consultant
	4.Strengthen Advocacy, Communication and Social Mobilization (ACSM) unit	Human resource, Funding, Office equipment	Q1 2024	MOH, Partners
	5. Use and distribution of the advocacy kits, IEC materials and radio jingles at District and National level	Human resource, Funding, Communication , Logistics	2023 - 2027	Districts, MOH, Partners and Media

Strategic Pillar 4: Strengthening the resources mobilization, inter-sectoral collaboration for the elimination of NTD

Celebrations	Host of the World NTD Day - (World Neglected Tropical Diseases Day is observed every year on 30 January .)	Human resource, Media, Funding, Logistics, Meeting Hall, IEC materials	2024 - 2027 (26th - 30th January of each year)	Districts, MOH, Partners, Media
Master Plan launch	1. Meeting to Launch the National Master plan	Human resource, Media, Funding, Logistics, Meeting Hall, Communication	27th April 2023	MOH, Partners, Media
	2. Domestication of the National Master plan to help and develop District Master plans in 29 districts	Human resource, Media, Funding, Logistics, Meeting Hall, Communication	Q2 2023	Districts, MOH, Partners, Media
Companies whose activities directly affects CM-NTDs should collaborate directly or indirectly to combat the disease.	Conduct advocacy visit to policy makers, line Ministries and relevant companies.	Human resource, Media, Funding, Logistics, Communication, advocacy tools	2023 - 2027	MOH, Partners, Media

Section 3.2: Toward Programme Sustainability: Intensifying Coordination and Partnerships

NTD Structure

At present, there exist no national policies on control of NTDs. It is the desire to create a dedicated NTD Program structure which will make reporting, accountability and implementations of NTDs easy towards control and elimination in Malawi. It is difficult for donors and funders to have parallel communication channels towards providing support for disease specific NTDs in the country without coordination. This observation had contributed to the challenges that the NTD program had faced in implementing interventions and created serious gaps in Management of NTDs.

To align with best global practices, it is suggested that the National NTD structure should be administered under one office with subordinate Programme Managers in charge of specific diseases. This will involve a new organogram structure as presented in figure 10 below

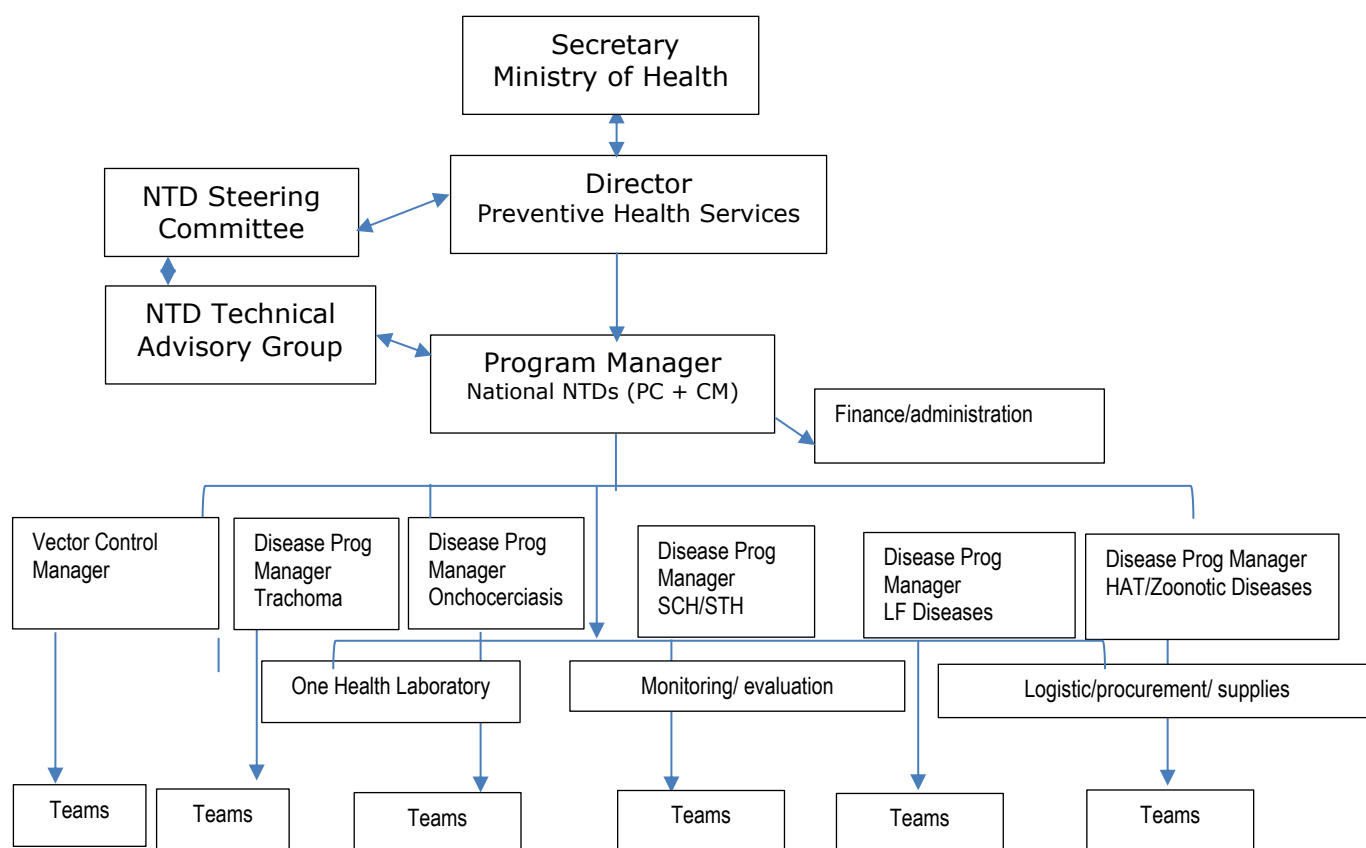


Figure 10: Proposed NTD structure for Malawi

At the national level there will be an NTD Program headed by a National Program Manager that is in-charge of the day-to-day management of the NTD secretariat, and will be assisted by the various programme-specific managers. There will be a technical committee, the NTD Steering Committee, which oversees programme implementation in the country. Relevant line ministries and government agencies will be represented in the Steering Committee which provides the platform for collaboration of the Ministry

of Health and other relevant government agencies for the implementation of NTD programme activities. This structure will be replicated in the 29 Districts.

Programme coordination

Table 28. Membership and Terms of Reference – Program Coordination Mechanism

Entity	Membership	Terms of Reference
National NTD Steering Committee		
Meeting frequency: Bi-annual Chair: Host: MoH	Academics and consultants	<ol style="list-style-type: none"> 1. Support programme development for implementation of control/elimination/eradication/management of neglected tropical diseases 2. Facilitate collaboration between MOH, partners, NGOS and other stakeholders in the implementation of control/elimination, eradication of NTDs and integration of activities in the health systems 3. Provide technical advice to programme managers 4. Facilitate financial support for ridding Malawi of NTDs 5. Carry out and facilitate operational research in Neglected Tropical Diseases
National NTD Secretariat (National Review Meeting)		
Meeting frequency: Annually Chair: National NTD Manage Host: MoH		
Districts' NTD Technical Advisory Committees		
Meeting frequency: Annually or Bi-annually (Depends on		<ol style="list-style-type: none"> 1. Provide regular technical advice to Programme Managers (PMs) 2. Support programme development for implementation of control / elimination / eradication and management of Neglected Tropical Diseases, for instance, by providing technical support for work plan development. 3. Facilitate collaboration between Ministry

Districts) Host: District Health Officer		of Health, District Health Teams, Partners / Non-Government Organisations and other Stakeholders with the aim of building sustainable partnerships in the control / elimination / eradication and management of NTD. 4. Carry out advocacy and facilitate resource mobilization for NTD Programme. 5. Facilitate operational research in Neglected Tropical Diseases as well as the health systems involved in their control / elimination / eradication and management. 6. Facilitate the policy and process of integration through the inclusion of NTD Programmes activities into the broader health system in an atmosphere of strong community involvement.
--	--	--

Partnership Matrix

Table 29. Partnership Matrix

Districts	NTDs	VETERINARY	WASH	ONE HEALTH	EDUCATION	MALARIA
Mangochi	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Nkhotakota	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Mwanza	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Nkhata Bay	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Salima	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Zomba	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Balaka	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart,	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI

	WaterAid, BICO, PMRA					
Blantyre	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Chiradzulu	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Lilongwe	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Mzimba North	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Mzimba South	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Neno	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Ntcheu	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Ntchisi	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research	PMI, USAID, Global Fund, WHO, World Vision, PSI

	Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA		SAVERS, WaterAid		Institutions, GIZ	
Chikwawa	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Chitipa	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Dedza	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Dowa	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Karonga	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Kasungu	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Machinga	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Mchinji	WHO, SIGHT SAVERS,	Min of Agric Vet Dept	Dept of Water and Nat.	Min of Agric Vet	Dept of Parks and Wildlife,	PMI, USAID, Global Fund,

	GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA		Resources, UNICEF, SIGHT SAVERS, WaterAid	Dept	Academic and Research Institutions, GIZ	WHO, World Vision, PSI
Mulanje	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Nsanje	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Phalombe	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Rumphi	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI
Thyolo	WHO, DNDi, SIGHT SAVERS, GLIDE, Tea Association of Malawi, CBM, Heart to Heart, WaterAid, BICO, PMRA	Min of Agric Vet Dept	Dept of Water and Nat. Resources, UNICEF, SIGHT SAVERS, WaterAid	Min of Agric Vet Dept	Dept of Parks and Wildlife, Academic and Research Institutions, GIZ	PMI, USAID, Global Fund, WHO, World Vision, PSI

Section 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 30. Risk Criteria and Assessment

Potential Risk	Before risk mitigation			Risk Mitigation	After risk mitigation		
	Likelihood of occurrence	Impact	Score		Likelihood of occurrence	Impact	Score
	Certain = 5 Likely = 4 Possible = 3 Unlikely = 2 Rare = 1	Severe = 5 Major = 4 Moderate = 3 Minor = 2 Insignificant = 1	Likelihood x Impact		Certain = 5 Likely = 4 Possible = 3 Unlikely = 2 Rare = 1	Severe = 5 Major = 4 Moderate = 3 Minor = 2 Insignificant = 1	Likelihood x Impact
Risk Type = Operational Risks							
Security challenges	2	1	2	Promote and maintain peace and good governance	2	1	2
Flooding	1	1	1	Distribute relief supplies and create awareness	2	1	2
Famine	1	1	1	Improve and sustain food security	1	1	1
Risk Type = Financial Risks							
Donor fatigue	2	2	4	Improve resource mobilization and domestic financing	2	2	4
Pull out of partners	2	3	6	Improve resource mobilization and domestic financing	2	2	4

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

Risk 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 31: Steps to mitigate risk	
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 are the strategic objectives, and the indicators, targets and date to track performances are provided.

Performance and Accountability Framework

Table 32a. Performance Indicators for Pillar 1: Accelerating programmatic action			
Strategic Priority	Performance Indicators	Target	Frequency/ Period of Reporting
Strategic priority 1: Accelerate progress from confirmation of a disease to mapping, screening and transform NTD surveillance into a core intervention	No of Districts with completed mapping of PC-NTDs	29 IUs	2024
	No of Districts with completed mapping of CM-NTDs	29IUs	2024
	No of IUs where co-ordinated mapping was conducted	9 IUs	2024
	No of NTDs with surveillance integrated into the routine health system	4	2024
	Approved policy and guidelines on NTDs available		2023
	No of cases reported for each CM NTD	All endemic IUs	Annually
	Reduction in specific-NTD disease morbidity and prevalence	All targeted NTDs	2027
Strategic priority 2: Prioritize and strengthen monitoring and evaluation to track progress and decision making towards the 2030 goals	Guidelines for NTDs M & E available and in use		2023
	Existence of a central storage for the integrated NTDs database that is fully functional and effective		2023
	User-friendly software for integrated NTDs data management developed and in use		2023

	No & proportion of IUs using integrated NTDs recording and reporting forms	29 IUs	2023
	No & Proportion of IUs submitting adequately completed NTDs Summary forms	29 IUs	2023
	Number of Integrated monitoring visits carried out per year	6	Annually
	No of IUs that implemented NTD-specific impact assessment activities	5 IUs	Annually - from 2023
	No & proportion of IUs that passed NTD-specific impact assessments	5 IUs	Annually - from 2024
	No & proportion of IUs where transmission for any NTD has been interrupted	20 IUs	Annually - from 2025
Strategic objective 4: Strengthen advocacy, visibility and profile of NTDs for the elimination interventions at all levels as “best buys”	Number & type of advocacy kits on NTDs produced	5	2024
	Number of line ministries/agencies and other stakeholders sensitized on integration with NTDs at each level	10	Annually
	No & proportion of Districts that held sensitization meetings	29 Districts	Annually
	Number of edition of newsletter/brief on NTDs produced annually	2	Annually
Strategic objective 5: Promote operational research and innovation as fundamental enablers of programmatic progress	Identified priority areas for operational research for NTDs available and circulated		2023
	No of O/R proposals on NTDs developed	10	Annually
	No of O/R conducted annually	5	Annually
	No of NTD personnel involved in NTD related	5	Annually

	O/R		
--	------------	--	--

Table 32b. Performance Indicators for Pillar 2: Intensify cross-cutting approaches			
Strategic Objective	Performance Indicators	Target	Date
Strategic objective 1: Strengthen identified platforms with similar delivery strategies and interventions (Vector Control) for integrated approaches across NTDs	No of trainings sessions held	6	Annually
	Number of NTD personnel/ health workers trained at each level	100	Annually
	Number of integrated NTDs tools produced & in use	2	Annually
	No of persons treated for each NTD	All individuals in endemic IUs	Annually /Bi-annually
	No of Communities treated for each PCT NTD	All eligible Communities in endemic IUs	Annually /Bi-annually
	No of IUs reporting integrated treatment	29 IUs	Annually /Bi-annually
	No of IUs with 100% geographic coverage for each NTD	20 IUs	Annually /Bi-annually
	No of IUs where 100% of endemic /target Community achieve at least 80% therapeutic coverage	20 IUs	Annually /Bi-annually
Strategic objective 2: Mainstream delivery platforms within the national health system	Number of sensitization meetings with key sector Policy makers	4	Annually
	Number of meetings held on mainstreaming delivery platforms with national health system	4	Annually
	No & Proportion of schools utilized for NTD implementation	50% of schools in endemic IUs	Annually

Strategic objective 3: Strengthen multi-sectoral coordination, collaboration, cooperation and foster partnerships in the prevention, treatment and care of patients with NTDs at all levels of health care	Number of community-based programmes collaborating with NTDs programme	5	Annually
	Number of partners supporting NTDs	5	Annually
	Number of line Ministries & Agencies supporting and collaborating with NTDs	6	Annually
Strategic objective 4: Strengthen capacity to implement NTD programme and resource mobilization, including the integration of NTD plan of action into the financial plans at all spheres	NTD Resource Mobilization manual available and in use		2023
	Number of participants at the training workshop on resource mobilization & management for NTD management teams	20	Annually
	Amount of resources being contributed by partners to NTDs		Annually
	No & Proportion of Districts releasing funds for NTD control	29 Districts	Annually

Table 32c. Performance Indicators for Pillar 3: Operating Models and culture to facilitate country ownership

Strategic Objective	Performance Indicators	Target	Date
Strategic objective 1: Promote and strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding	Number & proportion of Districts with established and functional NTD units	9 Districts	2024
	Number of IUs with focal persons for NTDs	29 IUs	2024
	Number of NTD partners meeting held annually	4	Annually
	No of steering committee meetings held in a year	1	Annually
Strategic objective 2:	Number of NTD	100	Annually

Empower Districts and authorities in social mobilization, behavioural change and building local support for NTD interventions	personnel/health workers mobilized at each level of implementation (including school teachers for school-based de-worming)		
	No of IUs providing local support for NTD interventions	29 Districts	Annually
	No of IUs conducting social mobilization, behavioural change activities	29 Districts	Annually
Strategic objective 3: Promote youth engagement to influence positive change and norms in favor of the national NTD programmes	Number of youth engagement sessions held	6	Annually
	Number of capacity building sessions for youths held	4	Annually
Strategic objective 4: Ensure donors, implementing partners and disease experts align their strategies and plans with the National NTD Plans	No of workshops conducted on NTD's	1 workshop per District	Annually
	Number and Proportion of implementing partners aligning their strategies with the national NTD Plan	All IPs	Annually
	Number of review/stakeholders meetings held	2	Annually
Strategic objective 5: Ensure development and review of integrated multiyear strategic plans and gender-sensitive annual operational plans for the control,	Number of meetings with districts to develop strategic plans for effective NTD implementation	2	2024
	No of training sessions held on development of district annual work	2	Annually

elimination and eradication of targeted NTDs at national and sub-national levels	plans		
	No & proportion of districts/IUs that developed and are using strategic /operational plans	29	2024

Table 32d. Performance Indicators for Pillar 4: Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs

Strategic Objective	Performance Indicators	Target	Date
Strategic objective 1: Promote community involvement and ownership of the program for optimal use of available resources	Number of Districts sensitized on NTDs	All endemic districts	Annually
	Number of Districts supporting NTD programme implementation	All endemic districts	Annually
	Number of Districts selecting distributors for MDA	All endemic districts	Annually
Strategic objective 2: Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs	Number of Districts where leaders are sensitizing community members on NTDs	All endemic districts	Annually
	Number of Districts having NTDs materials for awareness	All endemic districts	Annually
	Number and type of materials distributed at the community level		Annually

PART 4

Budgeting for Impact: Estimates

4.1 Introduction

The proposed NTD Master Plan (2023-2027) governs the prevention, control and, where feasible, elimination and eradication of neglected tropical diseases.

Information on cost of providing health care services is becoming increasingly important. This part presents cost estimates under the strategic Plan. The costs are based on data derived from programme-specific strategic targets, published documents on unit costs, and informed by previous costing experience in executing NTD health delivery services. The data was processed in the TIPAC excel based app to generate the overall costing estimates.

Part 4 describes in detail the level of resource requirements for the strategic plan, the results will help health program implementers, policy makers, and funders by generating evidence to support advocacy NTD services and resource mobilization, to improve NTD resource allocation, planning and budgeting, and to help improve NTD system performance. The information from the analyses will be important for developing investment cases and for facilitating the calculation of the health and economic impact of NTD interventions.

4.2 Costing Methodology

The costing combined both the TIPAC costing tool and the ABC costing tool. The Tool for Integrated Planning and Costing (TIPAC) which is a Microsoft excel program accurately estimated the health programs. The Neglected Tropical Disease (NTD) TIPAC was effectively used to plan and coordinate future program resources. TIPAC focuses on 5 Preventative Chemotherapy (PC) NTDs namely; Lymphatic Filariasis (LF), Trachoma, Schistosomiasis (SCH), Onchocerciasis and soil-transmitted helminths (STH) and the endemicity of other diseases in Malawi

4.3 Total resource requirements (2023 – 2030)

The cost estimates show that, the NTD activities will need **USD 57,558,492.91** excluding drugs which normally are provided by donor partners to implement interventions for the five-year period. It has to be pointed out that it is unlikely that the government of Malawi would be able to meet all the budgetary needs. The partners in the fight against NTDs also contribute a significant proportion for the success of the NTD battle. Below is the summary of the budget

Table 33. Summary of Budget estimates for the major activities

Examples of Strategic Pillar	Examples of priorities	TOTAL BUDGET	
		MWK	USD
		59,170,130,716.50	57,558,492.91
Pillar 1. Accelerating programmatic action	1) Scale up integrated preventive chemotherapy to achieve	17,222,129,422.00	16,753,044.18
	2) Prioritize and strengthen monitoring and evaluation to track progress and decision making towards the 2030 goals		
	3) Ensure timely, safe, and effective supply chain management of quality-assured NTD Medicines and other products up to the last mile		
Pillar 2. Intensify cross-cutting approaches	1) Strengthen identified platforms with similar delivery strategies and interventions (MDAs, skin NTDs, Morbidity management, WASH, One Health, etc) for integrated approaches across NTDs	14,324,967,794.50	13,934,793.57
	2) Mainstream delivery platforms within the national health system		
	3) Integrate safety across NTD planning, implementation, and monitoring		
Pillar 3. Operating Models and culture to facilitate country ownership	1) Promote and strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding	27,179,997,892.00	26,439,686.67
	2) Empower local government and authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions		
Pillar 4. Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs	1) Promote community involvement and ownership of the program for optimal use of available resources	443,035,608.00	430,968.49
	2) Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.		

1 USD= MWK 1028

Table 34: Detailed budgeting of activities

DETAILED BUDGET				
Strategic Pillar	Examples of priorities	Activity	<u>MWK</u>	<u>USD</u>
Pillar 1. Accelerating programmatic action	1) Scale up integrated preventive chemotherapy to achieve	Strategic Planning	94,785,000.00	92,203.31
	2) Prioritize and strengthen monitoring and evaluation to track progress and decision making towards the 2030 goals	Monitoring & Evaluation	266,324,269.00	259,070.30
	3) Ensure timely, safe, and effective supply chain management of quality-assured NTD Medicines and other products up to the last mile	MDA registration	54,432,292.00	52,949.70
		MDA drug distribution	960,227,000.00	934,072.96
		Mapping	1,406,922,080.00	1,368,601.25
		Infrastructure	14,439,438,781.00	14,046,146.67
			17,222,129,422.00	16,753,044.18
Pillar 2. Intensify cross-cutting approaches	1) Strengthen identified platforms with similar delivery strategies and interventions (MDAs, skin NTDs, Morbidity management, WASH, One Health, etc) for integrated approaches across NTDs	Vector Control	9,856,374,060.00	9,587,912.51
	2) Mainstream delivery platforms within the national health system	Strategic planning	96,832,000.00	94,194.55
	3) Integrate safety across NTD planning, implementation, and monitoring	Monitoring and evaluation	2,494,281,626.50	2,426,343.99
		Training	445,159,306.00	433,034.34
		Drug logistics	731,338,402.00	711,418.68

		Morbidity control and surgeries	700,982,400.00	681,889.49
			14,324,967,794.50	13,934,793.57
Pillar 3. Operating Models and culture to facilitate country ownership	1) Promote and strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding	Advocacy	798,685,000.00	776,930.93
	2) Empower local government and authorities in social mobilization, risk and crisis communication, behavioural change and building local support for NTD interventions	Training	198,239,000.00	192,839.49
		Social mobilization	183,073,892.00	178,087.44
		Setting up centralized Secretariat	12,000,000,000.00	11,673,151.75
		Technical capacity (labs, , infrastructure)	14,000,000,000.00	13,618,677.04
		Personnel	93,071,512.00	90,536.49
			27,179,997,892.00	26,439,686.67
Pillar 4. Strengthen Resource Mobilization, Coordination and Communication for the elimination of NTDs	1) Promote community involvement and ownership of the program for optimal use of available resources	Social mobilization	5,392,000.00	5,245.14
	2) Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.	Community involvements	437,643,608.00	425,723.35
			443,035,608.00	430,968.49
	EXCHANGE RATE : 1028 MWK= 1 USD		59,170,130,716.50	57,558,492.91
			MWK	USD

4.4 Financial Gap Analysis

The budget does not capture the difference between the resource requirements and the available resource- gap in funding which exists if the Master plan is to be fully implemented. The identification of the funding gap provides an opportunity for potential stakeholders to see when resources can be most useful.

The financing gap is usually estimated by generating the difference between the available resources from the government source and the cost of implementing the NTD Master plan. However in this current circumstance there is no data available on the availability of resources from donors, government or private sector. However, this tool can be used as an advocacy tool for mobilization of resources towards elimination of NTDs.

Strategies to ensure that available resources are sustained

Strategies to mobilize resources from new sources.

- Conducting stakeholder mapping for identification of areas of support Identification of potential donors both bilateral and multi-lateral
- Conduct resource mobilization engagement and advocacy meetings.
- Identification, appointment, and accreditation of eminent persons in the community as resource mobilization good will ambassadors

Strategies to ensure efficiency in resource utilization.

- Thorough planning for utilization of the allocated resources (SWOT analysis)
- Implementation plans with clear timelines.
- Continuous monitoring of impact process indicators
- Periodic evaluation objectives if they have been achieved as planned.
- Establishment of partner engagement and accountability framework

References

1. Malawi 2018 Population and Housing National Statistical Office. National Statistical Office May 2019.
2. Gabrielle Laing, Marco Antonio Natal Vigilato, Sarah Cleaveland, S M Thumbi, Lucille Blumberg, Naseem Salahuddin, Bernadette Abela-Ridder, Wendy Harrison, One Health for neglected tropical diseases, Transactions of The Royal Society of Tropical Medicine and Hygiene, Volume 115, Issue 2, February 2021, Pages 182–184, <https://doi.org/10.1093/trstmh/traa117>
3. Government of Malawi (2006) National School Health and Nutrition Baseline Survey
4. Grace, D., Mutua, F., Ochungo, P., Kruska, R.L., Jones, K. et al. 2012. Mapping of poverty and likely zoonoses hotspots. BMJ 2007;15:257-292 July ISSN 0966-6494
5. International Livestock Research Institute (ILRI). 2022. ILRI One Health Strategy: Stopping the global rise of high-impact zoonotic disease, foodborne disease and antimicrobial resistance. Nairobi, Kenya. <http://erepository.uonbi.ac.ke/>
6. *Malawi Multiple Indicator Cluster Survey 2019-20*. National Statistical Office *December 2021*
7. The 2015-16 Malawi Demographic and Health Survey (2015-16 MDHS). National Statistical Office (NSO) [Malawi] and ICF. 2017. Zomba, Malawi.
8. UNICEF's work in Malawi: Reports, strategies, studies, evaluations, data and fact-sheets (2022). Publications | UNICEF Malawi
9. WaterAid Malawi Country Programme (2022) <https://www.wateraid.org/mw/publications>
10. WHO. (2004) A national survey of the prevalence of Schistosomiasis and soil –transmitted helminthes
11. WHO (2007) Soil Transmitted Helminths, Geneva.
12. Some of the information came from the original document by the consultants.
13. The economic context of Malawi - Economic and Political Overview - International Trade Portal International Trade Portal (lloydsbanktrade.com)
14. G Davison. Malawi Medical Journal, 94-98. December 1991. Vol. 7