



Republic of Rwanda
Ministry of Health



NEGLECTED TROPICAL DISEASES STRATEGIC PLAN 2026-2030



July 2026



NEGLECTED TROPICAL DISEASES STRATEGIC PLAN 2026-2030

Preface

Rwanda has achieved substantial progress over the past decade, including nationwide scale-up of mass drug administration (MDA) for soil-transmitted helminths (STH) and schistosomiasis (SCH) and reduction of their prevalence, validation of Rhodesiense Human African Trypanosomiasis (Sleeping Sickness) elimination as a public health problem, and near-elimination of Lymphatic Filariasis (LF) and Trachoma. These successes are results of good leadership and accountability enhanced by decentralized and integrated Neglected Tropical Diseases (NTDs) services delivery, and multisectoral collaboration.

Despite this progress, several NTDs including STH (Ascariasis, Trichuriasis and Hookworm), SCH, Scabies and other ectoparasites (Tungiasis or Jigger disease), Podoconiosis, Rabies, Snakebite envenoming (SBE), Taeniasis/Cysticercosis, Onchocerciasis (River Blindness), Leprosy remains endemic in Rwanda. All these NTDs collectively constitute a major obstacle to socio-economic development and quality of life of the Rwandan people.

The Rwanda NTD Strategic Plan has been developed in line with the WHO NTD Roadmap 2021–2030, Kigali Declaration on NTDs, the Health Sector Strategic Plan V (HSSP V), and the National Strategy for Transformation (NST2), ensuring that NTD interventions contribute directly to Universal Health Coverage (UHC) and the Sustainable Development Goals. The review of the previous NTD Strategic Plan 2019-2024 informed the development of the strategic directions, objectives and targets of the NTD Strategic Plan 2026-2030.

This NTD Strategic Plan or NTD master plan (most used terminology in NTDs international community) will be implemented in compliance with the national vision, the MOH will be leading its implementation through Rwanda Biomedical Centre (RBC). The goal is to make Rwanda free from NTDs through the implementation of WHO recommended public health strategies for prevention and control of NTDs. These interventions include preventive chemotherapy, case management, vector control and surveillance, provision of safe water, improved sanitation and hygiene and veterinary public health.

The Ministry of Health in close collaboration with other social cluster Ministries, private sector, and key stakeholders will jointly implement this plan emphasizing on One Health framework and ensuring that the community-level and schools serve as the primary implementation platforms.

The Ministry of Health will contribute through domestic budget allocation for NTDs while continuing to engage development partners to mobilize additional resources required for implementation.

I am confident that this sector-wide NTD Strategic Plan will direct interventions to significantly reduce the burden of NTDs in Rwanda, and I call upon all stakeholders to play an active role in its implementation to enable the country to achieve its vision of a nation free from NTDs.



Dr. Sabin NSANZIMANA
Minister of Health

Acknowledgement

The Ministry of Health and the Rwanda Biomedical Centre (RBC) appreciates the effort and commitment of all partners and stakeholders in the fight against NTDs in Rwanda.

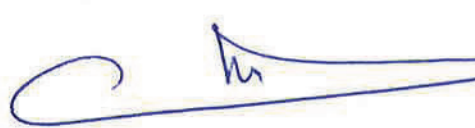
The development of this NTD Strategic Plan 2026-2030 reflects the collective commitment, expertise, and collaboration of numerous individuals and institutions dedicated to improving the health and well-being of the Rwandan population.

We extend our sincere appreciation to all stakeholders who dedicated their time, knowledge, and experience throughout the development of this plan. Special recognition goes to the members of the NTD-Sub Technical Working Group whose valuable insights helped shape the strategic priorities and interventions outlined in this document.

We are deeply grateful to our development partners, government institutions, academic institutions, civil society organizations, and implementing partners for their technical and financial support, constructive feedback, and continued commitment to the control and elimination of NTDs in Rwanda. Their partnership has been instrumental in ensuring that this Strategic Plan is evidence-based, responsive to national priorities, and aligned with global and regional NTD targets.

We also acknowledge the contributions of communities, community health workers, teachers, local leaders, and all those involved in NTD prevention, surveillance, treatment, and disability management. Their dedication and engagement remain critical to achieving the goals of this Strategic Plan.

As Rwanda advances toward the elimination of neglected tropical diseases as a public health problem, we look forward to continued collaboration and shared responsibility in implementing this Strategic Plan and improving the lives of all Rwandans.


Prof. MUVUNYI MAMBO Claude
Director General of RBC



Abbreviations and Acronyms

CBHI	Community-Based Health Insurance
cEMR	Community Electronic Medical Record
CHW	Community Health Worker
CLTS	Community-Led Total Sanitation
DHIS2	District Health Information Software 2
DHMT	District Health Management Team
DQA	Data Quality Assessment
DRG	Diagnosis-Related Group
eHMIS	Electronic Health Management Information System
EICV7	Seventh Integrated Household Living Conditions Survey (Enquête Intégrale sur les Conditions de Vie des Ménages)
eLMIS	Electronic Logistics Management Information System
ESPEN	Expanded Special Project for the Elimination of Neglected Tropical Diseases
FDA	Food and Drug Authority
FTS	Filariasis Test Strip
GPW14	Fourteenth General Programme of Work
HAT	Human African Trypanosomiasis
HMIS	Health Management Information System
HSSP V	Health Sector Strategic Plan V
ICT	Immuno-Chromatographic Test
ID-TWG	Infectious Diseases Technical Working Group
IEC	Information, Education, and Communication
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net
IU	Implementation Unit
JADF	Joint Action Development Forum
KK	Kato-Katz
KPI	Key Performance Indicator
LF	Lymphatic Filariasis
LLIN	Long-Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDA	Mass Drug Administration
MIGEPROF	Ministry of Gender and Family Promotion
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MININFRA	Ministry of Infrastructure
MMDP	Morbidity Management and Disability Prevention
MoH	Ministry of Health
MoU	Memorandum of Understanding
NCC	Neurocysticercosis
NHIC	National Health Intelligence Center
NST2	National Strategy for Transformation 2
NTD	Neglected Tropical Disease
OPD	Other Parasitic Diseases
PEP	Post-Exposure Prophylaxis
PEST	Political, Economic, Social, and Technological
PHC	Primary Health Care
POC-CCA	Point-Of-Care Circulating Cathodic Antigen
Podo	Podoconiosis
RAB	Rwanda Agriculture and Animal Resources Development Board
RBC	Rwanda Biomedical Centre
REMO	Rapid Epidemiological Mapping of Onchocerciasis



RMS	Rwanda Medical Supply
RNP	Rwanda National Police
RWB	Rwanda Water and Sanitation Board
SBC	Social and Behavior Change
SBE	Snakebite Envenoming
SCH	Schistosomiasis
SDG	Sustainable Development Goals
SOP	Standard Operating Procedure
STH	Soil-Transmitted Helminths
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TAS	Transmission Assessment Survey
TT	Trachomatous Trichiasis
TWG	Technical Working Group
UGHE	University of Global Health Equity
UHC	Universal Health Coverage
UR	University of Rwanda
WASAC	Water and Sanitation Corporation
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

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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 incidence 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.

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.

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.)

Purpose of the Document

This strategic plan provides a comprehensive framework for the elimination, control, and eventual eradication of neglected tropical diseases (NTDs) in Rwanda for the period 2026–2030. It aligns Rwanda's efforts with the WHO NTD Roadmap 2021–2030, the Health Sector Strategic Plan V (HSSP V), and the National Strategy for Transformation (NST2), ensuring that NTD interventions contribute directly to Universal Health Coverage (UHC) and the Sustainable Development Goals.

The plan serves as a practical guide for policy-makers, programme managers, district health teams, implementing partners, and development partners. It defines Rwanda's mission, vision, strategic goals, disease-specific targets, and cross-cutting priorities, providing a unified results framework to coordinate resources, measure progress, and strengthen accountability among stakeholders.

Covering all endemic NTDs and cross-sectoral interventions, this document is intended to:

- Guide **annual and multi-year planning**, budgeting, and prioritization of interventions.
- Provide a **basis for performance monitoring and reporting** at district, national, and global levels.
- Facilitate **partner alignment and resource mobilization**, ensuring efficient use of domestic and external funding.
- Support **adaptive management**, enabling timely course corrections based on data and evidence.

By articulating a clear pathway from 2026 to 2030, this plan establishes a shared commitment to eliminate NTDs as a public health problem, reduce inequities, and strengthen Rwanda's health system resilience.

Executive Summary



Mission	Vision
To eliminate NTDs as a public health problem in Rwanda and protect over 13 million people through integrated, equitable, and sustainable approaches.	A Rwanda free of Neglected Tropical Diseases.



Context and Rationale

Neglected Tropical Diseases (NTDs) continue to affect the most vulnerable populations in Rwanda, contributing to preventable morbidity, disability, and productivity losses. An estimated 13 million people continue to be at risk of at least one NTD, with rural and underserved communities bearing a disproportionate burden. The Government of Rwanda, through the Ministry of Health and the Rwanda Biomedical Centre (RBC), has achieved substantial progress over the past decade, including nationwide scale-up of mass drug administration (MDA) for soil-transmitted helminths (STH) and schistosomiasis (SCH), validation of Human African Trypanosomiasis elimination as a public health, and near-elimination of Lymphatic Filariasis (LF) and Trachoma.

Additionally, the introduction of the three-drug multidrug therapy (3-drug MDT), together with contact tracing and chemoprophylaxis, has contributed to a steady decline in leprosy case, and with a detection rate of 0.2 cases per 10,000 inhabitants, Rwanda has reached the cut-off for leprosy elimination as a public health threat. The persistence of leprosy among children and grade 2 disabilities are indicators of ongoing infection transmission and late diagnosis, respectively.

Building on these achievements and learning from challenges, the National NTD Strategic Plan 2026–2030 provides a comprehensive and integrated framework to eliminate, control, or eradicate priority NTDs in alignment with the WHO NTD Roadmap 2021–2030, the Health Sector Strategic Plan V (HSSP V), and the National Strategy for Transformation (NST2). The Plan emphasizes equity, integration into primary health care, evidence-based decision-making, strengthened country ownership, and sustainable domestic financing.

Strategic Goals and Targets

In line with global guidance, the Plan adopts four strategic goal categories with clear national targets by 2030:

- **Disease Eradication:** Submission of the yaws interruption of transmission verification dossier and achievement of WHO eradication certification.
- **Elimination (Interruption of Transmission):** Interruption of transmission of onchocerciasis and leprosy, and piloting interruption of transmission for STH and SCH in selected areas.
- **Elimination as a Public Health Problem:** Sustaining LF elimination and achieving WHO validation, achieving and sustaining trachoma elimination, maintaining SCH and STH below WHO-defined morbidity thresholds, and achieving zero human deaths from dog-mediated rabies.
- **Disease Control:** Institutionalization of case detection and clinical care for snakebite envenoming (SBE), mycetoma, scabies, tungiasis, taeniasis, podoconiosis, and cysticercosis, with integration into national health information systems.

Cross-cutting national targets include universal provision of integrated NTD services at health centre level, expanded school-based deworming and NTD-WASH education, increased domestic financing to at least 70% of program needs, and expanded coverage of community-based health insurance for NTD morbidity management.

Strategic Pillars and Approach

The Strategy is organized around four mutually reinforcing pillars:

- **Accelerating Disease-Specific Interventions and Elimination:** Scaling up preventive chemotherapy, morbidity management and disability prevention, and intensified disease management to achieve and sustain disease-specific targets.

- **Strengthening Cross-Cutting and Integrated Approaches:** Embedding NTD interventions within primary health care, school health, WASH, One Health, and community platforms to improve efficiency, coverage, and sustainability.
- **Enhancing Systems, Capacity, and Country Ownership:** Strengthening human resources, supervision and monitoring systems, supply chains, research capacity, and governance mechanisms at national and subnational levels.
- **Sustainable Financing and Partnerships:** Mobilizing domestic resources, aligning partners around national priorities, engaging the private sector, and reinforcing multisectoral and district-level governance platforms.

Performance and Accountability Framework

Implementation of the Strategy is underpinned by a robust Performance and Accountability Framework aligned with the WHO Compendium of NTD Indicators and harmonised with Rwanda's DHIS2 and National Health Intelligence Center (NHIC). Performance management will be operationalized through routine quarterly and annual reviews, mid-term and end-term evaluations, and strengthened data quality assurance processes. Standardized dashboards at district and national levels will support evidence-based microplanning, resource allocation, morbidity management scale-up, and elimination verification.

Costing and Resource Mobilization

The Strategic Plan is supported by a comprehensive, activity-based budget estimated at **RWF 13.79 billion** over the strategy period. The costing reflects Rwanda's epidemiological profile and the strategic shift from disease-specific mass interventions toward integrated, people-centred delivery platforms embedded in primary health care, community systems, and routine surveillance.

Approximately two-thirds of resources are allocated to disease-specific elimination and maintenance of gains, including the transition to routine deworming, scale-up of morbidity management and disability prevention, enhanced surveillance, and completion and maintenance of WHO elimination dossiers. Complementary investments support integration into PHC, WASH, HMIS/DHIS2, One Health platforms, and community delivery systems, while a smaller but critical share is dedicated to institutional capacity strengthening, financing sustainability, partner alignment, and multisectoral coordination.

Costing assumptions, coverage targets, and unit costs are documented in the accompanying NTD Costing Tool and are sequenced to reflect realistic phases of scale-up, consolidation, and sustainability. Following confirmation of ongoing onchocerciasis transmission, a separate National Onchocerciasis Elimination Plan has been developed and costed; its implementation is fully aligned with this Strategy's governance, service delivery, and monitoring frameworks.

Expected Outcomes by 2030

By 2030, Rwanda will have achieved or sustained elimination targets for priority NTDs, interrupted transmission of selected diseases, reduced morbidity from neglected conditions, and institutionalized NTD planning, financing, and reporting within national and district health systems. These outcomes will contribute directly to universal health coverage, health system resilience, and equitable health gains.

Call to action

This Strategic Plan provides a unified results framework for government institutions, development partners, civil society, academia, and communities. Through coordinated action, strengthened systems, and sustained investment, Rwanda can consolidate its gains and position itself as a regional leader in the sustainable elimination and control of NTDs.

1. Introduction

Rwanda remains committed to the global and regional agenda to end the burden of neglected tropical diseases (NTDs) by 2030. Like many countries in the WHO African Region—which bears nearly 40% of the global NTD burden—Rwanda faces the challenge of multiple NTDs that disproportionately affect rural, underserved populations and perpetuate cycles of poverty, poor health, and limited economic productivity¹.

Currently, Rwanda is endemic for a number of priority NTDs, STH, SCH, Snakebite Envenoming, Rabies, Leprosy, Taeniasis/Cysticercosis, Tungiasis, Podoconiosis, and onchocerciasis. These diseases primarily impact the most vulnerable groups, particularly in rural communities where access to clean water, sanitation, and health services remain inadequate.

In response, Rwanda has developed this National NTD Strategic Plan (2026–2030) as a comprehensive multi-year plan, guiding all stakeholders in achieving the national goal of NTD control, elimination, and, where possible, eradication. The Plan aligns with the WHO NTD Roadmap 2021–2030, the fourteen General Programme of Work (GPW14), and the Sustainable Development Goals (SDGs). It further reflects regional and global commitments made under the London Declaration, Kigali Declaration on NTDs, the Addis Ababa Commitment, and the Accra Call to Action.

Recognizing the varying epidemiological stages and intervention requirements of different NTDs, this revised Plan adopts a refined strategic framework. It categorizes national objectives into four distinct, WHO-aligned strategic goals: **eradication** (for diseases where global elimination is feasible), **elimination of transmission** (halting local spread), **elimination as a public health problem** (reducing burden below a critical threshold), and **control** (managing impact to a locally acceptable level). This targeted approach will ensure that resources and interventions are optimally aligned with the specific public health challenge presented by each disease.

The current Strategic Plan is grounded in an evidence-based situation analysis, identifying priority gaps and interventions across several strategic objectives. It emphasizes:

1. Government ownership and sustainability
2. Integration of NTD services into primary health care
3. Cross-sectoral collaboration through the One Health approach
4. Equity and gender inclusion
5. Community engagement and social behavior change
6. Strengthened surveillance and monitoring frameworks
7. Resource mobilization, including domestic financing

Guided by the Second National Strategy for Transformation (NST2), which is nested under Vision 2050, and aligned with Rwanda's Health Sector Strategic Plan V (2024–2029), the Plan outlines measurable national targets for 2030. It serves as a unified framework for coordination, harmonization, and alignment of interventions across government, development partners, civil society, and communities. Full integration of this strategy into national and sub-national health planning instruments will be critical to ensuring the sustainability and long-term impact of its interventions.

Progress on implementation, including outputs and outcomes—will be tracked through routine monitoring and evaluation, with periodic reviews to support learning and adaptive programming.

¹ World Health Organization (2020). Ending the neglect to attain the Sustainable Development Goals: A road map for neglected tropical diseases 2021–2030. Geneva: WHO.

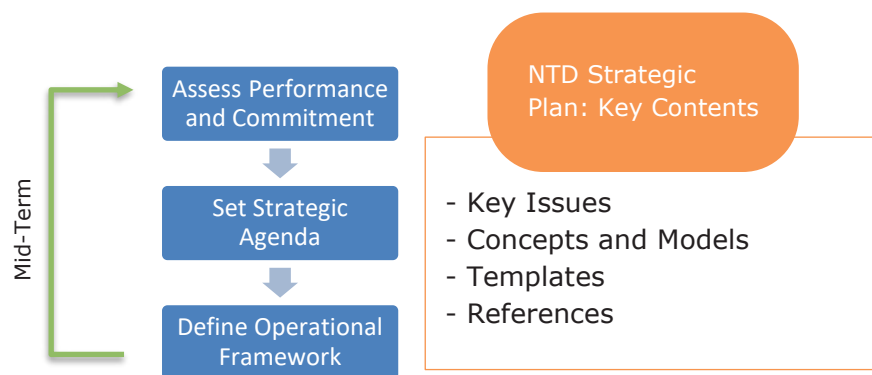


Figure 1. NTD Strategic Plan Key Contents



Figure 2. NTD Master Plan: Process and Management Cycles

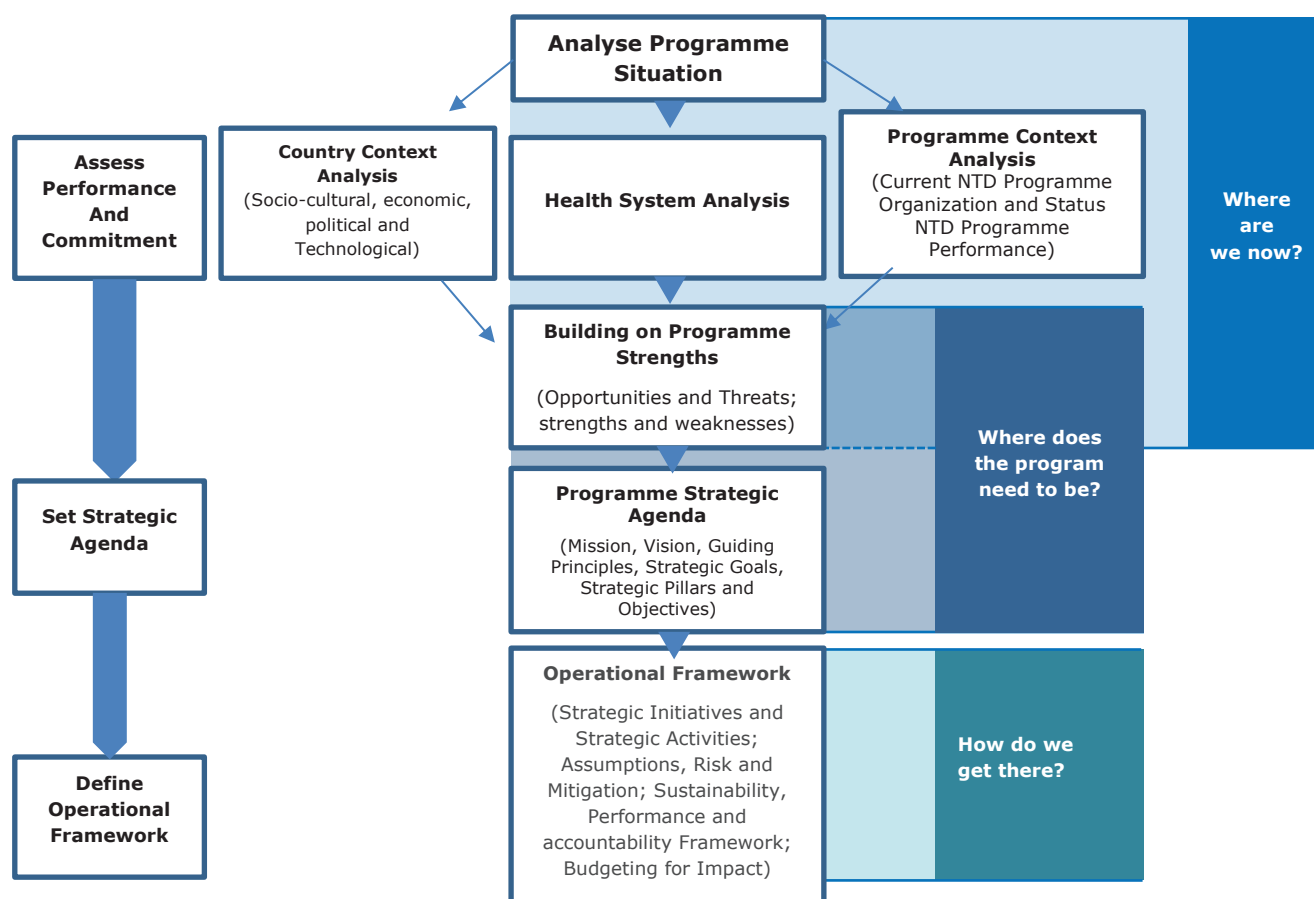


Figure 3. NTD Master Plan Process

Table 1. NTD Master Plan Tools

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

2. NTD Situation Analysis

2.1 National Priorities and the national, regional and global NTD Commitments

Neglected Tropical Diseases (NTDs) continued to be a major public health and development challenge in Rwanda, disproportionately affecting poor and marginalized populations, particularly in rural areas. These diseases, including Soil-Transmitted Helminthiasis (STH), Trachoma, Onchocerciasis, Lymphatic Filariasis (LF), Podoconiosis, Tungiasis, Scabies, Cysticercosis, and Rabies, are closely linked to poverty, poor sanitation, and limited access to quality healthcare. While not always fatal, NTDs are responsible for long-term disability, reduced productivity, and delayed cognitive and physical development in children, thereby reinforcing cycles of poverty and undermining national development goals. Moreover, NTDs contribute to and are exacerbated by malnutrition—particularly among children—through mechanisms such as nutrient malabsorption, chronic inflammation, and anaemia, compounding their vulnerability and impeding healthy growth and development.^{2,3}

Historically, NTDs have received limited attention and funding both globally and within health systems. However, over the past decade, momentum has grown at national, regional, and global levels to accelerate progress toward their elimination. Rwanda has actively participated in these efforts, achieving notable progress in mass drug administration (MDA), disease mapping, and elimination of Human African Trypanosomiasis (HAT) as a public health problem in 2022. Despite these advances, the country continues to face challenges, including inconsistent implementation, gaps in morbidity management services, underdiagnoses, and dependency on donor-driven funding models. In the same line, leprosy is no longer a public health issue in Rwanda; however, the elimination process is hindered by gaps related to early detection and quality treatment, jeopardizing the prevention of leprosy-associated disabilities and infection transmission reduction in the community.

The Rwanda National NTD Strategic Plan 2026–2030 is fully aligned with the World Health Organization's NTD Roadmap 2021–2030, which outlines global targets and introduces three critical shifts in approach. These include a focus on increasing accountability by using impact-oriented indicators; transitioning from vertical, disease-specific programming toward integrated delivery within primary health systems; and strengthening domestic ownership and financing to reduce dependence on external partners. These shifts are reinforced by Rwanda's commitment to regional and continental frameworks such as the Kigali Declaration on NTDs, the African Union's Continental Framework for NTD Elimination, the Addis Ababa Commitment, and the Accra Call to Action. Rwanda's engagement in the Expanded Special Project for the Elimination of NTDs (ESPEN) further strengthens its ability to access technical support, medicine donation mechanisms, and tools for improving data-driven decision-making.

At the national level, this strategy builds on the Health Sector Strategic Plan V (2024–2029), Vision 2050, and the National Strategy for Transformation 2 (NST2, 2024–2029), all of which emphasize human capital development, universal health coverage, and poverty reduction. Health is a cornerstone of Rwanda's development model, and the country's success in expanding community-based health insurance (CBHI) to over 90% of the population provides an important platform for integrating NTD services into routine care. The new strategy draws upon findings from the 2024 review of the previous NTD Strategic Plan (2019–2024), which showed that only 38 percent of planned activities had been fully implemented. Key constraints included very limited staffing, coordination challenges across sectors, and financing shortfalls. Nevertheless, the same review documented major progress, including consistently high MDA coverage rates for STH and Schistosomiasis, as well as early advances in post-elimination surveillance systems for Onchocerciasis. However, recent investigations—still pending full publication—have reported suspected and confirmed cases of Onchocerciasis in border areas near the DRC and Burundi, prompting a renewed focus on active surveillance and risk mapping.

² WHO (2020). Soil-transmitted helminth infections. <https://www.who.int/news-room/fact-sheets/detail/soil-transmitted-helminth-infections>

³ Hotez PJ et al. (2019). "Neglected Tropical Diseases and the Global Burden of Malnutrition: Scientific and Policy Priorities." PLOS Neglected Tropical Diseases

The plan recognizes that achieving national NTD goals requires collaboration beyond the health sector. It embraces an integrated, cross-sectoral approach that involves actors in private sector, education, infrastructure, WASH, agriculture, animal health, and local governance. This approach reflects the “One Health” philosophy and the principle that sustainable NTD control cannot be achieved in isolation from improvements in water, sanitation, hygiene, education, and social protection. It also acknowledges the strong correlation between NTD burden and poverty. According to EICV7 Data (2024), the national poverty rate has declined from 39.8% in 2017 to 27.4% in 2024, but a portion of the population continues to face socioeconomic vulnerability. Addressing NTDs is essential to improving equity, productivity, and community resilience.

Through evidence-based planning, this strategy outlines seven strategic objectives and corresponding interventions to accelerate NTD control and elimination efforts. These objectives focus on scaling integrated services, improving access to morbidity care, strengthening surveillance, and ensuring the financial and institutional sustainability of the programme. Progress will be monitored and evaluated at regular intervals, with clear mechanisms for partner coordination, resource alignment, and accountability. The Rwanda National NTD Strategic Plan 2026–2030 serves not only as a roadmap for action but also as a platform for renewed commitment across sectors and stakeholders—united in the goal of achieving a Rwanda free from the burden of neglected tropical diseases.

2.2 National Context Analysis

2.1.1. Country Analysis

Rwanda, a landlocked country in the heart of East Africa, shares borders with Uganda, Tanzania, Burundi, and the Democratic Republic of Congo. Despite its compact size of approximately 26,338 square kilometers, Rwanda is one of the most densely populated countries in Sub-Saharan Africa, with a population of over 13.2 million people as of the 2022 census. The terrain is highly varied, with altitudes ranging from 900 to over 4,000 meters, creating diverse ecological zones that influence both vector ecology and the epidemiology of NTDs.

The country has made significant strides in health system development, universal health coverage, and socioeconomic transformation, supported by a decentralized administrative structure comprising villages, cells, sectors, districts, and provinces. Over 70 percent of the population resides in rural areas, primarily engaged in subsistence farming, which contributes to continued exposure to environmental and behavioral risk factors for NTDs.

Rwanda’s youthful population — with more than half under the age of 30 — is both an opportunity and a vulnerability. While the demographic dividend offers future economic potential, it also places pressure on the health and education systems and exacerbates NTD exposure, particularly among children, who are biologically and socially more vulnerable to infection. Fertility rates have declined over time, and life expectancy has increased to 69.6 years.

In developing this strategic plan, a comprehensive assessment of the broader operating environment was conducted through Political, Economic, Social and Technological **(PEST) analysis** — examining political, economic, social, and technological factors that may influence implementation over the 2026–2030 period. This situational review is consistent with WHO guidance and aims to define the assumptions under which Rwanda’s NTD programming will unfold.

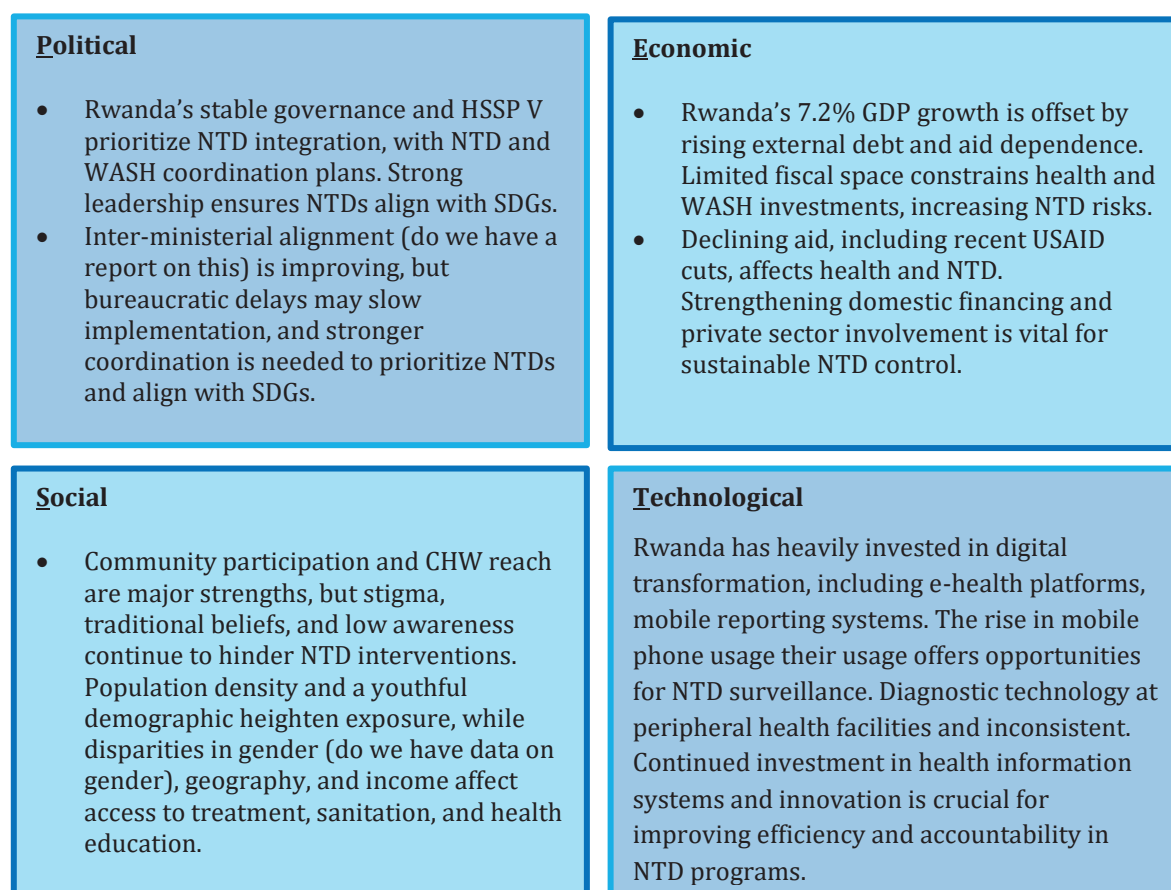


Figure 4. The PEST analysis

2.1.2. Health Systems Analysis

2.1.2.1. Health system goals and priorities

Rwanda's health sector is guided by a national vision of building a resilient, equitable, and people-centered health system capable of responding effectively to the country's disease burden. The Health Sector Strategic Plan V (HSSP V) 2024–2029 outlines the strategic direction of the Ministry of Health (MoH), aligning with broader frameworks including Vision 2050, the National Strategy for Transformation (NST2), and global commitments such as Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs). The health sector's key goals are to improve population health outcomes, enhance quality of care, and strengthen service delivery to be responsive to emerging public health challenges—including NTDs.

Service delivery in Rwanda is built upon a decentralized model, empowering local governments and district health authorities to lead planning, implementation, and monitoring of health interventions. The Ministry of Health acts as the steward of the sector, coordinating a wide range of stakeholders, including government institutions, civil society, development partners, and the private sector, to ensure harmonised planning and resource allocation. The Rwanda Biomedical Centre (RBC), as the technical implementing agency, plays a central role in public health research, disease prevention, surveillance, and control programs—including for malaria and NTDs.

While Rwanda has made significant progress in health outcomes, such as increasing life expectancy from 64.5 years in 2012 to 69.6 years in 2022, the burden of neglected tropical diseases continue to be a challenge. NTDs are not always reflected among the most reported health conditions at facility level due to underdiagnosis and limited routine data capture. Nevertheless, they have a profound impact on morbidity, productivity, and socioeconomic wellbeing, particularly in rural communities. As such, integrating NTD interventions into broader health systems strengthening is essential for long-term sustainability and equity.

2.1.2.2. Analysis of the overall health system

Rwanda's health system is structured into three interconnected levels of care—primary, secondary, and tertiary—ensuring comprehensive healthcare access for its population. This tiered system is guided by the Health Sector Strategic Plan V (HSSP V), which outlines the strategic direction and priorities for the health sector from July 2024 to June 2029. The implementation of the HSSP V is a collaborative effort spearheaded by the Ministry of Health (MOH) in partnership with a wide range of stakeholders, including socio-economic sectors, academia, the private sector, development partners, NGOs, faith-based organizations, and CSOs.

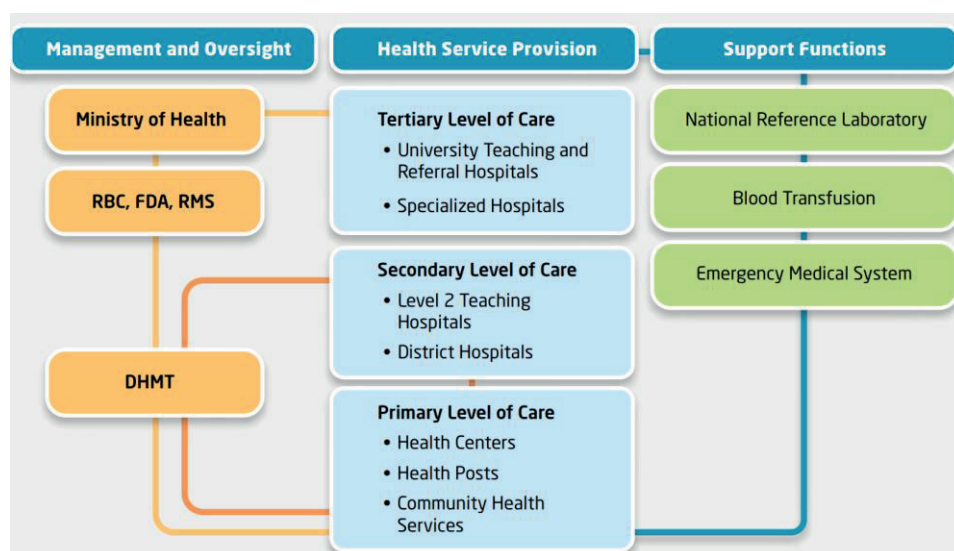


Figure 5. Rwanda Health Service Delivery Tier – Adopted from HSSP V

2.1.2.3. Management and Oversight

The MOH leads, coordinates, and provides policy guidance for implementing the HSSP V. The MOH is instrumental in aligning investments with national strategies, such as Vision 2050 and NST2, as well as district-level plans. This alignment is facilitated through close collaboration with MINECOFIN and other relevant ministries. The MOH coordinates its efforts through various agencies, including the RBC, Rwanda Medical Supply (RMS), and the Rwanda Food and Drug Authority (FDA), which serve as the primary implementing bodies.

The RBC, a key agency under the Ministry of Health, plays a vital role in the nation's healthcare system. RBC conducts scientific research, provides diagnostic services, and implements health interventions. Its responsibilities encompass health promotion, disease prevention, maternal and child health programs, blood and vaccine safety, healthcare technology, and epidemic control for diseases such as HIV, TB, and Malaria. Additionally, RBC contributes to financial sustainability through its research activities and strives to position Rwanda as a leading biomedical hub.

The Planning, Monitoring & Evaluation, and Health Financing Department of the MOH oversees the annual planning and budgeting process, ensuring that interventions, priorities, and investments from all stakeholders are integrated. At the decentralized level, District Health Management Teams (DHMTs) oversee local implementation of health policies and service delivery.

Table 2 below presents an analysis of Rwanda's health system, based on the WHO framework for strengthening health systems, focusing on six building blocks: service delivery, health workforce, health information, medical products and technologies, financing, and leadership and governance:

Table 2. Six Health System Building Blocks

Service delivery	Rwanda's health system is structured into three interlinked levels: primary, secondary, and tertiary care. Primary healthcare forms the foundation of service delivery, ensuring that essential health services are accessible to all, especially in rural and underserved areas. This level includes 1,154 health posts, 533 health centers, and over 58,000 Community Health Workers (CHWs) who serve as the first point of contact for many households. CHWs provide promotive, preventive, and curative services, and are integral to community mobilization, early detection, and delivery of interventions like Mass Drug Administration (MDA) for NTDs. Secondary care is provided at 55 district hospitals, several of which have been upgraded to Level-2 teaching hospitals to support medical education and regional referral. Tertiary care is delivered through university teaching hospitals and national referral hospitals, which handle complex medical conditions and serve as training and research centers. Service delivery is supported by systems such as the Emergency Medical Services, the National Reference Laboratory, and the blood transfusion network, ensuring continuity of care and response capacity. Despite these achievements, the quality of service delivery remains inconsistent, particularly in lower-level facilities. Challenges include staff shortages, equipment maintenance issues, and infrastructure gaps. Moreover, NTD-related morbidity management—such as lymphedema care or hydrocele surgery—remains underdeveloped in many areas. The health system is increasingly leveraging innovations such as e-health platforms and community-based surveillance to enhance responsiveness and efficiency.
Health workforce	Rwanda has invested in expanding its health workforce, yet the country continues to face significant human resource challenges. As of December 2023, Rwanda had approximately 1.2 licensed health professionals per 1,000 people—well below the WHO's SDG index threshold of 4.45 per 1,000. Only 61.3% of approved positions in the public sector are filled by appointed staff, and this figure rises to 75.2% when contractual workers are included. The shortage is particularly acute in specialized disciplines such as pharmacy, anesthesia, and surgery. Furthermore, disparities in distribution mean that rural and remote areas are less likely to attract and retain qualified personnel. High workloads, limited opportunities for career progression, and infrastructure constraints further reduce motivation and efficiency. There is also a misalignment between the curricula of health training institutions and the technological advancements in health information systems and telemedicine. Efforts to strengthen the health workforce include training initiatives, bonded scholarships, and decentralization of workforce planning to align supply with demand at local levels. CHWs remain a vital extension of the formal health system, particularly in the fight against NTDs. However, their training, supervision, and integration into health system planning still require improvement for maximum impact.
Health information	Rwanda has made significant strides in digital health infrastructure, developing a national electronic Health Management Information System (eHMIS) that collects data from public health facilities across all 30 districts. Innovations such as event-based surveillance systems, mobile reporting by CHWs, and real-time dashboards for disease surveillance have strengthened public health intelligence and outbreak preparedness. Nonetheless, several challenges persist. System interoperability is limited, with parallel digital platforms failing to share data effectively. Many facilities, particularly at the primary care level, lack the infrastructure or connectivity to fully utilize digital systems. Furthermore, private health facilities have low reporting rates, and some disease programs, including several NTDs, are not comprehensively captured in the national HMIS. There is also limited analytical capacity at district and facility levels, restricting the use of data for decision-making. To address these gaps, Rwanda is working on a centralized

	health data warehouse and improving health data governance frameworks. The integration of NTD indicators into routine surveillance and use of mobile tools for MDA reporting are key priorities.
Medical products	The availability and accessibility of essential medicines and health technologies are steadily improving. RMS—ensures the procurement and distribution of medical commodities to public facilities, while the Rwanda FDA provides regulatory oversight to ensure product safety and efficacy. Between 2020 and 2023, availability of essential medicines rose from 85% to 95%. However, challenges remain, particularly with last-mile delivery, stock-outs of NTD drugs in remote areas, and limited diagnostic tools at lower-level health facilities. There is also a significant gap in maintenance and calibration of medical equipment, with many facilities lacking the infrastructure or skilled personnel to manage equipment lifecycles effectively. To address these issues, Rwanda is promoting local pharmaceutical production. Three manufacturers have been licensed, and efforts are underway to reach WHO's Global Benchmarking Tool maturity level 3, enabling local production of vaccines and essential drugs. Improving cold chain capacity and ensuring adequate laboratory reagents and supplies are also ongoing priorities, especially for diseases requiring confirmatory testing such as schistosomiasis and soil-transmitted helminths.
Health financing	Rwanda's health financing landscape reflects a mix of public expenditure, community-based health insurance (CBHI), donor support, and private contributions. While total health expenditure has increased, it remains below the \$86 per capita target for UHC. The current per capita spending is approximately \$60, with 38.7% financed through external aid, 42% from public funds, and 19.3% from the private sector. The CBHI scheme, which covers over 90% of the population, is a central pillar of financial protection. However, sustainability concerns persist due to variable contributions and reliance on supplemental funding sources such as levies and traffic fines. Fee-for-service reimbursement models dominate, leading to inefficiencies and cost escalations. Strategic purchasing mechanisms like capitation and diagnosis-related groupings (DRGs) are not yet operational. Financing for NTDs remains largely donor-dependent. With recent reductions in bilateral aid—such as USAID cuts—there is increasing need to scale up domestic financing and explore innovative financing models, including leveraging private sector participation and integrating NTD services into the CBHI benefit package.
Governance	Governance of Rwanda's health sector is anchored in clear policies, legal frameworks, and institutional mandates. The Ministry of Health sets strategic priorities, provides regulatory oversight, and ensures alignment across stakeholders through mechanisms such as the Health Sector Working Group, Joint Sector Reviews, and various Technical Working Groups. At the national level, agencies like the Rwanda Biomedical Center (RBC), , and Rwanda FDA execute core technical and operational functions. The Malaria and Other Parasitic Diseases Division (MOPDD) and Tuberculosis and Other Respiratory Diseases Division (TBORD) within RBC leads NTD programming, supported by dedicated focal points and five technical units. A quarterly Malaria and NTD Technical Working Group ensures coordinated action with ministries of Agriculture, Education, Local Government, development partners, and civil society. Despite strong coordination frameworks, key governance gaps remain. These include limited leadership capacity at the district level, high turnover of skilled managers, and weak multisectoral engagement in NTD response. While many policies have been updated, gaps in enforcement and fragmented implementation persist. Investments in management training, leadership development, and policy coherence—particularly across WASH, education, and agriculture—are essential to support integrated NTD control and promote long-term sustainability.

2.3 Gap Assessment

While Rwanda has made notable progress in addressing NTDs, critical programmatic and systemic gaps remain. These must be addressed to consolidate gains, accelerate progress toward the 2030 elimination targets, and align national efforts with the WHO NTD Roadmap. The following analysis outlines key areas requiring strengthened action, with a focus on health system integration, surveillance, supply chain, financing, multi-sectoral collaboration, and monitoring and evaluation.

A persistent gap lies in NTD integration within the broader health system. Many services remain siloed, with limited incorporation of NTD case management into routine primary healthcare and laboratory services. While CHWs have played a key role in MDA campaigns, their full potential in morbidity management, surveillance, and patient follow-up remains underutilized due to training gaps, workload burdens, and insufficient incentives. Additionally, diagnostic capacity at lower-level health facilities remains weak. Health centres frequently lack standard tools, reagents, and trained personnel needed for consistent, high-quality diagnosis and morbidity management, especially for diseases such as STH, SCH, Lymphatic Filariasis, Onchocerciasis, Podoconiosis, Tungiasis, and Cysticercosis.

Moreover, the persistence of leprosy in endemic zones of Gisagara, Bugesera, Ngoma and Rusizi district and sporadic cases in other districts highlights another hurdle in the fight against NTD. Children accounted for 10.9% of 119 new cases between July 2020 and June 2025 and 17.9% of 28 in 24/25, indicating continuing transmission and recent infections. On the other hand, at diagnosis, 64.3% new cases had MB leprosy; 14.3% of new cases had grade 2 disabilities, which is an indicator for late diagnosis when leprosy complications have already started to manifest.

Leprosy symptoms can take up to five years to manifest. Additionally, cases are primarily identified in a limited number of sectors designated as endemic. This results in a lack of familiarity with the disease among health professionals, even those in endemic regions, which logically impairs case-finding efforts by health centres in these areas. For instance, 71.4% (85/119) of new leprosy cases enrolled by the program in the last five fiscal years were diagnosed during such campaigns, which are often conducted by the central-level teams in collaboration with health professionals from local health centres and local community leaders. Of them, only 21.2% (18/85) were diagnosed during such campaigns by health centres. Early detection, timely treatment initiation, and contact tracing remain essential priorities in halting leprosy infection transmission, an intermediate goal before leprosy elimination.

Surveillance and data integration gaps are also prominent. While Rwanda has made strides in digitizing data collection, NTD indicators are not yet fully integrated into the national Health Management Information System (HMIS). This fragmentation has led to parallel reporting channels, delays in real-time data use, and poor sub-national utilization of NTD data for decision-making. For diseases such as Onchocerciasis, Trachoma, and Lymphatic Filariasis—where Rwanda is currently establishing baseline endemicity status and planning targeted interventions—robust surveillance systems remain underdeveloped. Moreover, national disease maps and prevalence data for some NTDs remain outdated or incomplete, impeding precise targeting of interventions and efficient allocation of resources.

Supply chain bottlenecks continue to affect the availability and timely distribution of NTD medicines and commodities. Although RMS has branches in every district and health facilities technically have access, the NTD supply chain is not yet well-integrated. Some NTD-related medicines, such as those for morbidity management or vector control supplies, are not consistently available through routine channels and depend on external partner support, creating vulnerability to stockouts and interruptions.

Health financing for NTDs remains heavily reliant on donor funding, with domestic resources representing a small proportion of overall program support. Budget lines for NTDs are not clearly defined within national and district health budgets, limiting government ownership and sustainability. Recent reductions in external funding, such as cuts from USAID, have already disrupted programming and threaten long-term planning. Without a structured domestic financing strategy, including private sector engagement and innovative funding mechanisms, Rwanda risks reversing its hard-won gains.

There are also gaps in multi-sectoral collaboration, particularly with the WASH, education, agriculture, and local government sectors. While the Kigali Declaration and WHO Roadmap emphasize cross-sectoral approaches, coordination mechanisms in Rwanda remain weak and largely ad hoc.

Interventions such as school-based deworming, integration of hygiene promotion into health education, and zoonotic disease prevention remain underdeveloped due to fragmented planning and financing across sectors.

Finally, the capacity for strategic planning, monitoring and evaluation (M&E) needs further strengthening. Only 38% of activities in the previous strategic plan were fully implemented, highlighting a need for improved program coordination, staffing, supervision, and performance tracking. Technical capacity for disease-specific elimination dossier preparation is limited, and reporting to global monitoring frameworks is often delayed.

Rwanda's NTD program stands at a critical juncture. The foundational infrastructure and political will are in place, but systemic and disease-specific gaps must be urgently addressed to achieve 2030 elimination targets. Strengthening integration, surveillance, supply chains, financing, and multi-sectoral collaboration—while ensuring data-driven, community-centered programming—will be essential to move from control to elimination.

2.4 Program Context Analysis

2.1.3. Current NTD Programme Organization and Status

2.1.3.1. Soil-Transmitted Helminthiasis (STH)

Soil-Transmitted Helminthiasis (STH) continues to pose a major public health challenge in Rwanda, especially in rural areas. The overarching national goal for STH is its elimination as a public health problem. However, in selected subnational districts, efforts will be intensified to achieve the more ambitious goal of elimination of transmission.

From 2008 to 2020, Rwanda reduced STH prevalence among school-aged children and community members, from 65.8% to 38.8%. This progress is largely attributed to commendable MDA efforts. MDA coverage for children consistently reached over 95% from 2019 to 2023. A new policy in 2019 also led to a substantial increase in adult MDA coverage, from 57% in Round 1 of 2019 to 96% in 2022, reflecting a growing commitment to comprehensive control.

Despite progress in mass drug administration (MDA), re-infection risks for Soil-Transmitted Helminths (STH) persist due to ongoing environmental contamination, especially in settings with inadequate sanitation. This underscores the critical need for sustained, multisectoral efforts beyond MDA. Recent pilots, such as the transition strategy integrating routine deworming into health and education systems, signal important steps toward sustainable control. However, gaps remain—particularly the lack of structured NTD education in school curricula, limited WASH infrastructure in vulnerable communities, and the absence of preventive guidelines within agriculture, environmental management, and water bodies (e.g., lakes and rivers). Addressing these systemic and policy-level gaps is crucial for reducing re-infection and achieving subnational interruption of transmission. A similar gap analysis is warranted across other NTDs, including Schistosomiasis (SCH), Lymphatic Filariasis (LF), and Podoconiosis.

2.1.3.2. Schistosomiasis (SCH)

Schistosomiasis (SCH) or Bilharzia is a persistent health issue in Rwanda, particularly in wetland areas where transmission is driven by the presence of *Biomphalaria pfeifferi* and *sudanica* snails. Prevalence trends vary by diagnostic method: the Kato-Katz (KK) technique reported a stable but low prevalence at 2.7% in 2008, 1.9% in 2014, and 2.4% in 2020, likely underestimating infections due to its limited sensitivity, while the more sensitive Point-Of-Care Circulating Cathodic Antigen (POC-CCA) test, introduced in 2014, revealed a higher prevalence of 36.1%, which decreased to 25.6% by 2020, indicating a notable reduction but also ongoing transmission. A 2020 remapping using POC-CCA confirmed *Schistosoma mansoni* transmission across all mapping units, including areas previously deemed low-risk, with some schools in these zones showing significant prevalence, highlighting the need for updated mapping strategies. A malacological survey in 2022 found 130 out of 1,449 *Biomphalaria* snails shedding *S. mansoni* cercariae, particularly around lakeshores and wetlands, correlating with higher prevalence among preschool-aged children and emphasizing the role of snail

density in transmission. MDA efforts from 2019 to 2021 targeted 5,459,430 individuals, reaching 4,855,703 (89%), with annual coverage rates of 94% in 2019, 82% in 2020 (affected by COVID-19 disruptions), and 89% in 2021, reflecting resilience despite not reaching 100%. The evolving distribution, with new hotspots identified, suggests that integrating snail control with MDA and enhancing surveillance are essential to achieve elimination goals.

2.1.3.3. Trachoma

Trachoma's current status in Rwanda is uncertain due to the absence of recent data, with the last assessments conducted in 2007-2008. At that time, the disease was considered endemic in some regions, particularly in the Eastern Province, but no updated prevalence or risk factor data exists to confirm whether it remains a public health concern. The lack of evaluation mapping, surveillance, or mass treatment initiatives since 2008 suggests that Trachoma may have diminished as a priority, potentially due to improved hygiene and living conditions over the years, though this assumption cannot be verified without new surveys. The prolonged data gap creates a blind spot, making it challenging to assess the disease's geographic distribution or burden, and raises questions about whether Rwanda can confirm elimination without renewed efforts to map and monitor its status, especially in historically affected areas.

2.1.3.4. Onchocerciasis

While historical data classified Rwanda as hypo-endemic for Onchocerciasis or River Blindness based on the 1999 REMO survey, which found no need for community-directed treatment, the country is now re-evaluated this status. The entomological mapping of black fly vectors, combined with serological survey launched in 2024, confirmed ongoing transmission of onchocerciasis in focal areas of Rwanda (Rusizi and Nyamasheke districts) bordering the Democratic Republic of Congo and Burundi, where Onchocerciasis remains endemic. It changed the focus from elimination dossier preparation to renewed onchocerciasis elimination program.

2.1.3.5. Lymphatic Filariasis (LF)

Lymphatic Filariasis (LF) in Rwanda shows minimal evidence of endemicity, with historical data suggesting the disease is not a significant public health issue. Mapping in 2008 using immuno-chromatographic test (ICT) cards detected only one positive case out of 797 individuals across five districts, indicating an extremely low prevalence, and subsequent analyses attributed historical cases to non-filarial elephantiasis (podoconiosis) rather than LF. No active interventions, such as mass treatment or morbidity management, have been implemented in recent years, reflecting the lack of evidence for ongoing transmission. Instead, efforts are centered on preparing a validation dossier for WHO to confirm LF's non-endemic status and certify elimination, a strategic shift that aligns with the data but requires vigilance given the potential for reintroduction in a region where NTDs remain prevalent.

2.1.3.6. Podoconiosis

Podoconiosis is a notable concern in Rwanda, particularly in the North and West provinces, where a 2017 national prevalence study reported 68.5 cases per 100,000 people, with the highest rates in districts like Nyamasheke and Rusizi, linked to exposure to volcanic soil in highland areas. Significant progress has been made through the establishment of 13 treatment centers, with 11 new centers created through a partnership between HASA and the RBC, funded by the Izumi Foundation, complementing two existing facilities. These centers provide screening, treatment, and preventive services, supported by National Treatment Guidelines, awareness materials, and reporting tools, alongside the training of 22 health professionals (11 nurses and 11 physiotherapists) in podoconiosis management. Despite these advancements, coverage gaps persist in endemic districts, and cultural misconceptions associating the disease with supernatural causes hinder care-seeking behavior. Integrating podoconiosis care into primary healthcare and the national health insurance scheme could improve access and sustainability, addressing the socioeconomic burden on affected rural communities.

2.1.3.7. Snakebite Envenoming

Snakebites are an increasing public health issue in Rwanda, particularly affecting rural populations engaged in agriculture. From 2019 to 2021, districts like Nyagatare and Bugesera reported the highest numbers, with an upward trend in cases that may reflect heightened exposure or improved reporting. A 2012 study found snakes as the second leading cause of animal bites in 2017-2018, with 363 cases treated in hospitals, predominantly in the Eastern Province, where 61% of victims were women due to agricultural activities near wildlife habitats. Compliance with treatment guidelines was low, averaging 63%, with only 13% receiving antivenom, 4% vitamin K, and 31% tetanus toxoid, compounded by the fact that only three hospitals consistently stocked antivenom, which was suited for Asian rather than African snake species. Age distribution shows an even spread across groups, with a slight peak in the 16-30 age range due to outdoor occupational exposure, while males face higher rates overall. Treatment is nearly evenly split, with 51.6% of cases managed at facilities and 48.4% at home, indicating substantial barriers to accessing formal healthcare, particularly in rural areas. Outcomes include 15 fatalities out of 46 total bite deaths, alongside 335 disabilities, underscoring the need for better antivenom access, guideline adherence, and community education on prevention and first aid to mitigate severe complications.

2.1.3.8. Human Rabies

Dog bites in Rwanda are a growing concern, slightly outnumbering snakebites cases and posing a significant rabies transmission risk, particularly in rural districts. From 2019 to 2024, Nyagatare and Bugesera reported the highest incidence, with an upward trend that may stem from increased exposure or better reporting. Children aged 0-15 experience the highest incidence, likely due to frequent interactions with domestic animals and limited knowledge of safe handling, while females show a relatively higher proportion of dog bites, possibly due to household proximity to dogs. Anti-rabies vaccines are now delivered via Zipline drones, improving access, though the national vaccination coverage has not yet been comprehensively documented. Treatment is split, with 51.6% of cases managed at facilities and 48.4% at home, reflecting challenges in accessing timely care, especially in remote areas. Outcomes are concerning, with 22 fatalities out of 46 total bite deaths, alongside 5,323 recoveries and 335 disabilities, with 9 deaths uncategorized, highlighting data gaps. Robust dog vaccination programs, public education on safe animal interactions, and improved healthcare access are essential to reduce rabies risk and improve outcomes, particularly for vulnerable children and rural communities.

2.1.3.9. Cysticercosis

Cysticercosis in Rwanda affects both human and animal populations, driven by interconnected transmission dynamics in the south and southwest, where free-roaming pig husbandry facilitates the spread of *Taenia solium*. Studies show a high prevalence of porcine cysticercosis in these regions, correlating with 23.3% of epileptic patients in the Southern Province diagnosed with neurocysticercosis (NCC), reflecting a significant human burden. Current meat inspection practices, such as tongue palpation, detect only 43–48% of infected carcasses, exposing consumers to infected pork and perpetuating the parasite's lifecycle. Human diagnosis is hindered by limited access to neuroimaging, while risk factors include increasing age, lack of safe drinking water, and prior albendazole treatment, suggesting potential reinfection or treatment inefficacy. Breaking the transmission cycle requires a One Health approach—improving pig husbandry, enhancing sanitation, and increasing access to diagnostics and education to address both human and animal health risks.

2.1.3.10. Mycetoma and Yaws

Mycetoma and Yaws in Rwanda appear to have a minimal current burden, with limited recent activity or data to assess their status. Only one case of mycetoma was identified during the 2019-2024 period, suggesting a very low prevalence that does not warrant large-scale intervention. Yaws, historically endemic with 408 cases reported in the 1980s reducing to 17 by 1989, has not been surveyed since the 1990s, leaving its current status unknown, though the WHO categorizes Rwanda as previously endemic. A planned survey to confirm Yaws' status was halted by the COVID-19 pandemic, and no further cases have been reported, suggesting the disease may no longer be a public health issue. The Ministry of Health declared the elimination of six NTDs in 2022, pending WHO certification, which may

include Mycetoma and Yaws, but the absence of recent data creates uncertainty, necessitating targeted surveys to confirm their elimination and ensure no resurgence occurs.

2.1.3.11. Human African Trypanosomiasis (HAT)

Human African Trypanosomiasis (HAT) in Rwanda has been successfully eliminated, marking a significant public health achievement. Sentinel surveillance in 12 health centers surrounding Akagera National Park has been consistently maintained, ensuring early detection and control of potential cases, even as the disease burden has diminished. This sustained vigilance led to the submission of a dossier to WHO, resulting in official validation of elimination in 2022, announced by the Ministry of Health, with Rwanda receiving a WHO certificate for this milestone. The absence of reported cases in recent years reflects the effectiveness of Rwanda's health systems in managing and eradicating this disease, though continued surveillance remains critical to prevent reintroduction from neighboring regions where HAT persists.

2.1.3.12. Scabies

Scabies in Rwanda shows a varied burden across districts and provinces, with a general downward trend from 2019 to 2023, though surveillance gaps complicate a full assessment. Gakenke in the North Province consistently reported the highest cases, declining from 8,952 in 2019 to 1,586 in 2023, while Kamonyi in the South Province had the lowest, dropping from 2,383 to 95 over the same period. Other high-burden districts include Ngoma (East Province, 6,876 to 1,172) and Burera (North Province, 8,765 to 1,163), while Huye (South Province, 697 to 270) and Nyaruguru (South Province, 5,130 to 223) reported minimal cases. The sharp decline to near-zero cases in 2020, except in Bugesera (45 cases) and Nyagatare (101 cases), reflects the COVID-19 pandemic's impact on reporting, with recovery in 2021-2023 indicating resilient health system responses. Provincially, the Northern and Western Provinces initially bore the highest burden but saw significant declines by 2021, while the Eastern Province showed fluctuations with a slight rise in 2022 before decreasing, and the Southern Province and Kigali City maintained consistently low cases, likely due to better infrastructure in the capital. These inter-provincial variations suggest that targeted interventions in high-burden areas, coupled with improved surveillance, are necessary to sustain progress and address disparities in scabies control.

2.1.3.13. Tungiasis

Tungiasis is an emerging public health challenge in Rwanda, with a concerning rise in cases from 2019 to 2024, though data gaps hinder a complete picture. Initially underreported in 2019, likely due to limited awareness or surveillance, cases increased significantly in subsequent years, with districts like Gisagara, Nyamasheke, and Rubavu consistently reporting higher numbers, while others reported zero or very few cases, indicating uneven distribution or reporting practices. Provincially, the East had the highest burden, with cases rising from 1,144 in 2019 to 1,859 in 2023, driven by Bugesera and Ngoma, while the West saw a peak of 2,009 cases in 2021 (likely due to improved post-COVID-19 reporting) before decreasing to 1,212 in 2023, led by Karongi and Nyamasheke. The North reported an increase from 58 cases in 2019 to 1,014 in 2023, particularly in Gicumbi and Burera, and the South rose to 1,295 cases in 2023, driven by Huye and Nyamagabe, while Kigali Province had the lowest burden, decreasing from 724 to 329 in 2023, reflecting urban advantages like better health infrastructure. The absence of 2020 data, due to COVID-19 disruptions, underscores the need for strengthened surveillance, improved diagnostics, and targeted interventions in high-burden districts to address this growing issue effectively.

2.1.3.14. Leprosy

Rwanda has reported leprosy cases since the 1960s, however, with decreasing number of cases it is becoming a rare disease. Over the past five years, Rwanda reported 119 new leprosy cases, averaging 23.8 cases annually, with more than 89% originating from endemic sectors within the districts of Bugesera (Mareba, Nzangwa, and Gashora sectors), Nyaruguru, Ngoma (Jarama sector), Rusizi (Bugarama, Gikundamvura, and Butare sectors), and Gisagara (Gishubi and Kirarambogo sectors). In 24/25, the program recorded 28 new leprosy cases, depicting a new detection rate of 0.2 new cases per 100,000, well under the cut off for elimination as a public health problem.

Active case-finding campaigns are the primary approach to leprosy screening and case identification worldwide. For instance, of the last five fiscal years, 75.5% of 143 cases registered were identified through such campaigns. Additionally, in a passive way, people presenting themselves at health facilities and in active way where, in collaboration with local focal persons and central level staff during dermatology consultations. Awareness campaigns are organized to inform people about the early signs of leprosy so as to motivate them to present themselves for consultations. New patients are invited to bring their household contacts for examination and the eligible receive chemoprophylaxis and are monitored for 5 years.

The vast majority are diagnosis clinically, but skin smear results is sometimes the basis for MDT initiation when it is associated with strong clinical judgement in favour of active leprosy. From 1982 multidrug therapy (MDT) was introduced for all newly detected cases. MDT completion is above 95% for PB cases, however, MB cases on MDT for 12 months, between 2019 and 2023 have had an 87.2% rate.

Upon confirmation of leprosy, in addition to patient education, treatment initiation and contact tracing, the clinician ensures every case is recorded across all reporting platforms. Paper-based reporting tools include the index case individual file, treatment card, leprosy case register, and leprosy contact and Post Exposure Prophylaxis (PEP) register. Except for the contact register, these tools are filled out at diagnosis and updated monthly until the programme is completed. The leprosy contacts and PEP register is completed after contact tracing is conducted and is then updated annually until the contact is discharged from the programme, usually five years after enrolment.

Aggregated leprosy data are reported in the HMIS monthly. Since 2019, the e-Leprosy patients' tracker, a web-based, case-based reporting system, has been initiated to allow disaggregation by age, sex, place of residence and other relevant criteria. In addition, a dedicated Leprosy contact tracing tracker was also initiated to capture leprosy contacts' clinical information, demographics and other relevant details. Moreover, since 2014, the TB&ORD Division has submitted data for the DHIS2-based WHO Annual Leprosy Report to a WHO-controlled DHIS2

Table 3. National population data, schools, and health facilities at district level – (5PHC, 2022)

Province	Number of Admin A 2	Number IUs	No. of villages or communities*	Total population	U5 (Pre-school)**	5–1YR School age)***	No. primary schools	No. of peripheral health facilities			
								District Hospital	Referral ****	IU level	Health Centres
Kigali	3	35	1,163	1,745,555	128,810	209,804	458	5	4	na	39
Nyarugenge	10	10	350	374,319	26,367	43,891	71	2	1	Admin sector	12
Gasabo	15	15	486	879,505	68,986	110,768	263	2	1	Admin sector	18
Kicukiro	10	10	327	491,731	33,457	55,145	124	1	2	Admin sector	9
South	8	101	3,501	3,002,699	233,379	432,798	941	10	5	Admin sector	125
Nyanza	10	10	420	365,718	28,887	54,116	101	1	0	Admin sector	18
Gisagara	13	13	524	397,051	33,003	60,257	96	2	0	Admin sector	15
Nyaruguru	14	14	332	318,126	26,624	49,035	103	1	0	Admin sector	16
Huye	14	14	508	381,900	28,743	53,080	113	1	3	Admin sector	14
Nyamagabe	17	17	536	371,501	27,246	51,382	135	2	0	Admin sector	19
Ruhango	9	9	533	359,121	27,592	52,089	101	1	1	Admin sector	14
Muhanga	12	12	331	358,433	25,806	48,326	141	1	1	Admin sector	15
Kamonyi	12	12	317	450,849	35,478	64,513	151	1	0	Admin sector	14
West	7	96	3,617	2,896,484	247,007	459,885	936	10	2		122
Karongi	13	13	538	373,869	30,443	57,589	154	2	1	Admin sector	22
Rutsiro	13	13	484	369,180	30,266	57,830	114	1	0	Admin sector	17
Rubavu	12	12	519	546,683	48,944	86,757	133	1	0	Admin sector	14
Nyabihu	12	12	473	319,047	25,672	48,417	101	1	0	Admin sector	16
Ngororero	13	13	419	367,955	31,118	58,991	119	2	0	Admin sector	14
Rusizi	18	18	596	485,529	43,115	78,176	152	2	0	Admin sector	19
Nyamasheke	15	15	588	434,221	37,449	72,125	163	1	1	Admin sector	20
North	5	89	2,744	2,038,511	163,196	293,488	642	6	2		108
Rulindo	17	17	494	360,144	29,805	52,709	112	1	1	Admin sector	23
Gakenke	19	19	617	365,292	27,210	51,002	133	3	0	Admin sector	23
Musanze	15	15	432	476,522	37,559	67,139	142	0	1	Admin sector	17
Burera	17	17	571	387,729	33,284	58,484	125	1	0	Admin sector	19
Gicumbi	21	21	630	448,824	35,338	64,154	130	1	0	Admin sector	26
East	7	95	3,791	3,563,145	298,742	541,787	1064	8	2		120
Rwamagana	14	14	474	484,953	37,112	70,590	115	0	1	Admin sector	16
Nyagatare	14	14	628	653,861	58,600	100,717	260	2	0	Admin sector	20
Gatsibo	14	14	602	551,164	46,098	84,512	151	2	0	Admin sector	19
Kayanza	12	12	421	457,156	37,225	71,157	146	2	0	Admin sector	15
Kirehe	12	12	612	460,860	38,615	69,483	125	1	0	Admin sector	18
Ngoma	14	14	473	404,048	31,404	61,825	106	0	1	Admin sector	15
Bugesera	15	15	581	551,103	49,688	83,503	161	1	0	Admin sector	17
*Where implementation and administrative units are separate (e.g. onchocerciasis interventions), target communities in a district. ** Fifth Population and Housing Census - 2022 (considered 3–5-year-olds) (considered); ***Fifth Population and Housing Census – 2022 (considered 6–11); **** Referral and Teaching Hospital & Provincial Hospitals											

2.1.4. NTD Programme Performance

The performance of Rwanda's NTD programme reflects years of coordinated implementation, monitoring, and adaptation, informed by national surveys and operational assessments conducted in the years leading to this strategic plan.

Comprehensive mapping of STH and SCH has been completed across all 30 districts. However, updated data are required for several other NTDs such as trachoma, cysticercosis, among others. A remapping exercise using the more sensitive POC-CCA assay for SCH revealed ongoing transmission in areas previously considered low-risk, emphasizing the need for refined diagnostic strategies and more detailed surveillance.

Mass Drug Administration (MDA) campaigns for STH and SCH have achieved nationwide geographic coverage with consistently high implementation levels. For other NTDs, progress has varied. Rwanda achieved elimination of rhodesiense Human African Trypanosomiasis (r-HAT) as a public health problem, following the sustained maintenance of sentinel surveillance in 12 health centers near Akagera National Park and the successful submission of a dossier to WHO, which certified the country's elimination status in 2022.

Lymphatic Filariasis (LF) has not yet reached the elimination stage, and Rwanda is currently preparing to conduct baseline epidemiological surveys, including the screening of patients presenting with podoconiosis-like symptoms to exclude LF. Podoconiosis and other skin NTDs are gaining increasing attention, although interventions remain geographically limited and require expansion to achieve national scale.

Impact assessment surveys indicate progress in several areas, such as STH where prevalence declined from 45% in 2014 to below 20%. For SCH, the use of POC-CCA diagnostics has enhanced understanding of transmission dynamics, though it has also identified new areas of concern.

Leprosy remains endemic in four district in Rwanda. In the last 10 years, new leprosy cases have seen a 30% decline, compared to 10 previous years. Every affected person was initiated on MDT, however more emphasis is needed to avert complications associated with late diagnosis. Initiated in 2021 by enrolling households contacts in a retrospective and prospective fashions, contact tracing has reached 537 leprosy household contacts, and 68% of the eligible for chemoprophylaxis were initiated on chemoprophylaxis. Moving forward integration with other NTD-related activities will crucial to stop the infection transmission.

Since 2007, the control of STH and SCH has benefited from consistent and comprehensive support, including MDA, WASH interventions, and vector control. Integration of skin NTDs—such as scabies and tungiasis—into the primary healthcare system is underway, although national coverage remains insufficient. There have been modest improvements in case detection and reporting for rabies and snakebite envenoming (SBE), but further integration into emergency and primary care is necessary to ensure timely and equitable management.

Table 4. NTD Mapping Status

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
STH	30	30	30	0; but new impact assessment in all 30
SCH	30	30	30	0; but new impact assessment in all 30
SBE	30	30	30	Mapping needed
Dog Bites	30	30	30	Mapping needed
Tungiasis	30	30	30	Mapping needed
Podo	30	30	30	0
Scabies	30	30	0	30
HAT	30	0	30	Not endemic
TRA	30	0	0	0
Onchocerciasis	30	2	30	0
Leprosy	30	4	30	0
LF	30	0	30	0
(Mycetoma, Yaws etc	30	unknown	30	0

2.1.5. Performance of the other programs that are closely related to NTD program

2.1.5.1. Vector control

Vector control is a core component of national disease prevention efforts in Rwanda, implemented mainly through the malaria program and other public health initiatives. These efforts also benefit NTDs like lymphatic filariasis, schistosomiasis, onchocerciasis, and human African trypanosomiasis. Integrated methods such as indoor residual spraying (IRS), insecticide-treated nets (ITNs), larviciding, environmental sanitation, and space spraying help reduce other vector populations and interrupt disease transmission.

For instance, IRS and ITNs used for malaria also reduce LF transmission due to shared mosquito vectors. Larviciding and environmental management in malaria zones support SCH control by limiting snail and mosquito breeding. Additionally, traps and spraying are employed in certain districts to manage tsetse flies (HAT) and could act against blackflies (onchocerciasis) as well.

Although vector control for NTDs is not a standalone intervention, aligning strategies across disease programs could optimize coverage, resource use, and impact in areas where vector-borne NTDs are still endemic.

Table 5. Vectors and Associated NTDs

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

2.1.5.2. One-Health

Rwanda uses a multisectoral One Health approach to tackle health threats at the intersection of human, animal, and environmental health. The national framework is coordinated by a high-level Steering Committee including the Ministry of Health, Rwanda Biomedical Centre, Ministry of Agriculture and Animal Resources, and Rwanda Development Board. While traditionally focused on zoonotic and epidemic diseases like anthrax, avian influenza, and Ebola, One Health also aims to prevent and control priority NTDs such as dog-mediated rabies and snakebite envenoming (SBE).

Rabies control benefits from joint planning between human and animal health sectors, with periodic dog vaccination campaigns and post-exposure prophylaxis (PEP) delivery at health facilities. Dog bite reporting is integrated into HMIS, though coordination with veterinary systems remains inconsistent. For SBE, collaboration has begun in mapping snakebite hotspots and improving antivenom supply using Zipline. Community awareness initiatives for rabies and snakebites are conducted through school education and CHWs, but their reach is limited.

There is potential to enhance NTD-specific One Health integration by developing joint data-sharing systems, aligning response protocols between health sectors, and embedding community awareness into broader campaigns. Strengthening the One Health platform is essential for sustainably reducing zoonotic and environmentally linked NTDs in Rwanda.

2.1.5.3. Water, Sanitation, and Hygiene

Water, sanitation, and hygiene (WASH) are essential for the prevention and control of several NTDs in Rwanda, including STH, SCH, scabies, tungiasis, and podoconiosis. Rwanda has made progress in expanding access to basic water and improved sanitation services, although challenges remain in rural districts where these diseases are most common. National data indicate disparities in household water and sanitation coverage, and hygiene practices such as handwashing with soap are inconsistent.

WASH coordination is led by the Ministry of Infrastructure (MININFRA) and supported by partners such as UNICEF, WaterAid, and local civil society. However, coordination between WASH and NTD programs is weak, with no structured platform for joint planning or monitoring. Key WASH interventions, including rural water supply expansion, Community-Led Total Sanitation (CLTS), and hygiene education through schools and CHWs, are implemented without formal alignment to NTD disease burden or intervention targeting.

Currently, WASH-NTD integration is mainly limited to the use of hygiene messaging during MDA campaigns and school health programs. There is no systematic prioritization of WASH investments in high-burden NTD districts, nor are WASH indicators routinely monitored alongside NTD outcomes. Given the increasing incidence of skin-related NTDs such as scabies, tungiasis, and podoconiosis—conditions strongly influenced by hygiene and water access—better alignment between WASH and NTD actors is important.

The NTD program will work to improve intersectoral coordination by establishing formal connections with the national WASH coordination platform, advocating for inclusion of NTD indicators in WASH program frameworks, and ensuring that high-burden districts are prioritized for integrated hygiene and disease prevention programming.

The strong linkages between WASH and NTDs provide an opportunity for joint programming, especially for NTDs impacted by behavior, environment, and treatment-related WASH factors (see Annex X). Vector-borne NTDs like lymphatic filariasis and schistosomiasis are particularly sensitive to WASH improvements. Integrating WASH with environmental vector control measures (such as improved solid waste management and safe water storage) is essential to reducing transmission in urban and peri-urban settings, especially with rising risks due to climate change and rapid urbanization. This plan recommends that the Ministry of

Health, RBC, and WASAC explore formal joint planning with the WASH and Environment sectors, using WHO's BEST framework as a tool for coordinated priority setting.

Table 6. WHO BEST Framework table on WASH–NTD linkages and relevant vectors

Vector		Disease caused	Type of pathogen
Mosquito	Aedes	Chikungunya	Virus
		Dengue	Virus
		Lymphatic filariasis	Parasite
		Rift Valley fever	Virus
		Yellow Fever	Virus
		Zika	Virus
	Anopheles	Lymphatic filariasis	Parasite
		Malaria	Parasite
		O'nyong'nyong virus (ONNV)	Virus
Culex	Japanese encephalitis	Virus	
	Lymphatic filariasis	Parasite	
	West Nile fever	Virus	
Aquatic snails		Schistosomiasis (bilharziasis)	Parasite
Blackflies		Onchocerciasis (river blindness)	Parasite
Fleas		Plague (transmitted from rats to humans)	Bacteria
		Tungiasis	Ectoparasite
Sandflies		Leishmaniasis	Parasite
		Sandfly fever (phlebotomus fever)	Virus
Triatome bugs		Chagas disease (American trypanosomiasis)	Parasite
Tsetse flies		Sleeping sickness (African trypanosomiasis)	Parasite

2.1.6. Building on NTD Programme Strengths

The Rwanda NTD Programme benefits from a strong institutional and strategic foundation that positions it well for achieving national and global targets. Key strengths include:

- **Dedicated NTD Unit:** An NTD unit within the RBC coordinates planning, implementation, and monitoring of all programmatic activities.
- **ORD Unit** is responsible for conceiving, directing and coordinating leprosy control activities while providing technical support and necessary resources. Additionally, integrated with TB activities, Leprosy has a strong M&E framework.
- **Integration into National Health Strategy:** NTDs are explicitly included in the Health Sector Strategic Plan (HSSP), affirming government commitment to mainstream control and elimination activities within the broader health system.
- **Domestic Financing:** The Government of Rwanda continues to allocate domestic resources to NTD and leprosy activities, complementing donor funding and strengthening program sustainability.
- **Community-Based Health Insurance (CBHI):** Coverage for certain NTD-related services is included under the national CBHI scheme, enhancing financial access for affected populations.
- **Integration into Primary Health Care (PHC):** Routine NTD services are increasingly integrated into PHC delivery platforms, especially deworming interventions.
- **High MDA Coverage:** Rwanda has maintained consistently high national coverage rates for MDA campaigns, with effective cascade training and community engagement strategies.
- **Robust Community Delivery Platforms:** The use of (CHWs and local leadership structures has enabled successful decentralized outreach and follow-up.
- **Effective Multisectoral and Partner Engagement:** The program leverages strong relationships with bilateral and multilateral agencies, academic institutions, and NGOs—coordinated through national technical working groups (TWGs)—to mobilize resources, align technical support, and drive integrated interventions.
- **Routine M&E for Mass Drug Administration (MDA)** is supported through national reporting tools (like HMIS) and partner-led surveys (e.g., impact assessments for STH, SCH).

However, it faces internal challenges like human resource limits, weak diagnostics, management and surveillance systems, and inadequate integration with other health platforms (WASH, HMIS, and MCH Week), which hinder scaling and sustaining progress. Addressing these issues is crucial to meet 2030 targets.

Externally, opportunities include leveraging the One Health platform for rabies and SBE, aligning with the WASH-NTD agenda, and expanding community-based integration through CHWs and decentralized planning. The programme must protect against external threats such as funding instability, stigma, cross-border transmission, and climate-related vector changes.

2.1.6.1. Opportunities and Threats

The NTD programme can capitalize on several opportunities, such as the national One Health coordination mechanism, which provides an entry point for addressing zoonotic NTDs like rabies and snakebite envenoming (SBE). Furthermore, ongoing investments in WASH, digital health initiatives, and CHW systems offer robust platforms for delivering integrated interventions. Additionally, engaging with the private sector in logistics and health innovation presents significant untapped potential. Moreover,

However, the programme is also confronted with external threats beyond its direct control. These include funding uncertainties due to dependence on donors, climate variability that may expand vector habitats, persistent stigma associated with skin and disabling NTDs, and porous borders with countries where diseases such as Onchocerciasis and HAT remain endemic.

2.1.6.2. Strengths and Weaknesses

The programme's strengths include strong political will, robust CHW and school health delivery platforms, high MDA coverage, and an effective partner coordination environment. These are reinforced by national commitments under the 4x4 health workforce reform, domestic funding allocation to NTDs, and integration of NTD services into primary health care and community-based insurance (CBHI). The ongoing digitization of health services through eCHIS and efforts to integrate NTD indicators into routine HMIS further strengthen surveillance and delivery. Innovations such as drone delivery pilots and NTD–malaria integration are also emerging as operational advantages. These enablers contribute to sustained momentum toward controlling and eliminating NTDs.

However, systemic weaknesses persist. These include staffing gaps at national and district levels, limited access to diagnostics (especially for skin NTDs and zoonotic diseases), and under-resourced morbidity management. Post-MDA surveillance and integration with broader platforms (HMIS, WASH, MCH Week, One Health) remain limited. Budget constraints hinder procurement, quantification, and last-mile delivery of NTD commodities. Addressing these internal limitations is essential to meet Rwanda's 2030 goal of eliminating or controlling all endemic NTDs.

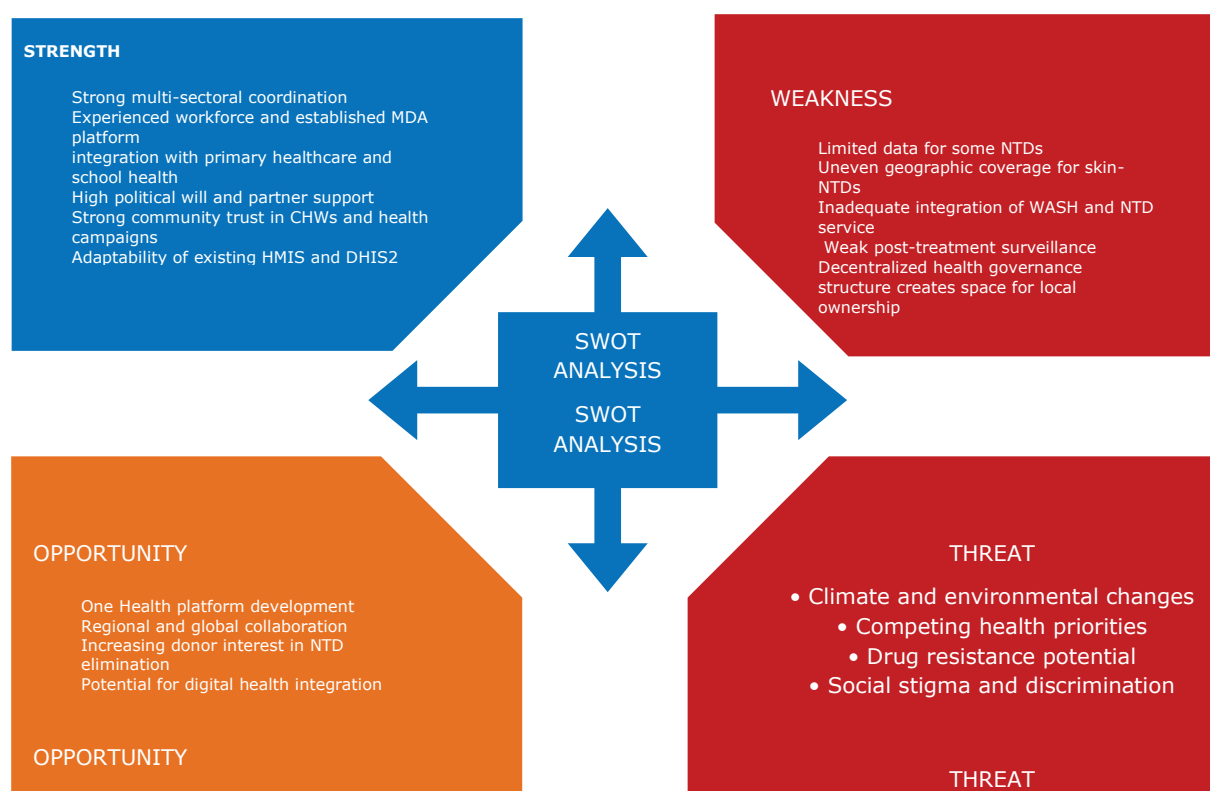


Figure 6. SWOT analysis

2.1.7. Gaps and priorities

Building on the SWOT analysis, several programmatic and strategic needs must be addressed to accelerate progress toward NTD elimination by 2030. The following section outlines key areas central to the success of Rwanda's NTD program.

Table 7. Gaps and priorities

Gaps	Priorities
Limited integration of NTD planning into broader health sector strategies.	Integrate NTD strategic planning into community, district and national health planning frameworks.
Fragmented coordination mechanisms across programs and districts.	Establish and operationalize multisectoral coordination platforms (e.g. One Health). And develop a multisectoral strategy and investment for NTD control
Inadequate decentralization of NTD management and operational decision-making.	Strengthen capacity of decentralized units to lead NTD implementation.
Limited private sector and cross-sectoral engagement.	Foster stronger collaboration between NTD programmes and WASH, education, animal health and veterinary services.
Uneven coordination of implementing partners at subnational levels.	Strengthen partner coordination mechanisms and mapping to reduce duplication.
Gaps in leveraging research institutions for innovation and evidence generation.	Build partnerships with academic and research institutions for operational research and innovation.

Incomplete geographic coverage for skin NTDs (e.g. podoconiosis, scabies).	Scale up MDA and morbidity management to underserved areas.
Limited availability of diagnostics and medicines for case management of some NTDs.	Ensure essential diagnostics and medicines for all priority NTDs are available at service delivery points.
Insufficient integration of NTD services into PHC.	Accelerate integration of NTD services within PHC and UHC frameworks.
Limited post-MDA surveillance and transmission assessment surveys for some NTDs. Weak systems for early detection of NTD outbreaks, especially for zoonotic and skin NTDs.	Develop and implement a national NTD M&E framework with clear KPIs and targets.
Insufficient granularity and timeliness of routine data on NTDs.	Institutionalize regular coverage and impact surveys.
Weak performance monitoring frameworks specific to NTDs.	Align NTD indicators with national and SDG reporting systems.
Limited access to up-to-date national impact and coverage assessments.	Strengthen domestic resource mobilization strategies and advocate for budget allocations in national health financing.
Lack of standardized indicators for some cross-cutting NTD interventions (e.g. vector control, WASH).	Upgrade the existing and develop digital tools to accommodate all NTDs indicators
Heavy dependence on external funding for NTD programs.	Advocacy for domestic resources allocation to NTDs
Late leprosy diagnosis (Between July 2019 to June 2025, 14.4% and 16.7 of 132 new cases had G1 and G2 Disability at MDT initiation. 60.6% of new cases had MB leprosy, 10.6 % of new cases were children)	Foster a bottom-up approach to all leprosy interventions and activities
Low MDT completion rate for MB leprosy cases (from July 2019 to June 2023, 87.2% of 47 new MB cases notified completed MDT. Only 62.5% in the 2024-2025 cohort, due to a high LTFU rate among the 8 new MB cases). Additionally, 17.4% of 121 new cases between July 2020 and June 2025 had G2D, while it was 14.3% in 24-25	Maintain high MDT completion and ensure adequate leprosy complication management during and after treatment
Low coverage of chemoprophylaxis (PEP-SDR) among Household's leprosy contacts, (baseline :68% over the last 5 FYs)	Optimise leprosy notification, contact tracing and PEP coverage for the eligible household contacts
Lack psycho-social support (only 2/8 cooperatives for former and current leprosy cases remain in operation, no framework for follow up following MDT completion)	Enhance wholistic care delivery for leprosy-affected persons

2.1.8. Strategic planning context

The year 2024 marked a critical transition period for Rwanda's Neglected Tropical Diseases (NTD) program. While the previous NTD Strategic Plan (2019–2024) formally concluded, the national program continued implementation throughout the year to ensure continuity of essential interventions. This transitional year also coincided with key developments at the national health planning level, most notably the launch of the HSSP V in February 2025.

The design of this new NTD Strategic Plan (2026–20230) was therefore intentionally deferred to follow the finalization of HSSP V, ensuring strong alignment with national priorities and the updated health sector framework. During 2024, a comprehensive review of the previous NTD plan was conducted, and the results informed the development of this strategy. The ongoing delivery of routine services—such as MDA, morbidity care, and surveillance—ensured no disruptions occurred during this transition.

This strategic alignment and seamless transition reinforce the Government of Rwanda's commitment to sustainability, continuity, and evidence-driven planning in the fight against NTDs.

3. Strategic Agenda: Purpose and Goals

The purpose of this strategic plan is to provide a clear and unified framework for the control, elimination, and sustained management of NTDs in Rwanda. Building on Rwanda's strong foundation in MDA, community health systems, and service delivery, this plan outlines a comprehensive, results-driven agenda that addresses the persistent gaps identified through national program reviews and stakeholder consultations. It serves as a roadmap for all actors—government institutions, implementing partners, civil society, research bodies, the private sector, and affected communities—to align their efforts toward the shared goal of eliminating the burden of NTDs as a public health problem.

3.1. NTD Programme Mission and Vision

Table 8. Mission and vision

Mission	To eliminate NTDs as a public health problem in Rwanda and protect over 14+ million people through integrated, equitable, and sustainable approaches.
Vision	A Rwanda free of NTDs.

3.2. Strategic Goals, Milestones and Targets

3.2.1. Categorization of NTDs by Global Targets and National Context

In alignment with the WHO NTD Roadmap 2021–2030 and based on Rwanda's national disease burden, surveillance findings, and programmatic realities, NTDs in Rwanda have been categorized into four goaltypes. These categories enable strategic tailoring of interventions and resources to achieve maximum impact.

Table 9. Global Alignment

Global Target	WHO Definition	Rwanda Alignment
Eradication	The permanent reduction to zero of the global incidence of infection caused by a specific pathogen through deliberate efforts, with no risk of reintroduction; formally verified through certification of eradication.	Yaws (not detected, under verification)
Elimination (Interruption of Transmission)	Schistosomiasis (SCH): Interruption of transmission is demonstrated by the absence of ongoing infections in humans (and, where relevant, animal reservoirs), with no evidence of transmission in intermediate snail hosts. Onchocerciasis: Interruption of transmission is demonstrated using defined serological and entomological criteria, specifically: - Prevalence <0.1% in children aged 5–9 years (as measured by Ov16 serology), and <0.05% of infected black flies (as measured by O-150 PCR). Leprosy: Interruption of transmission is defined as zero new autochthonous cases among children (<5 years of age) for at least five consecutive years.	Leprosy, Onchocerciasis, Schistosomiasis, STH* (*subnational)

	Elimination of leprosy as a public health problem is defined as zero new autochthonous cases across all age groups for at least three consecutive years.	
Elimination as a Public Health Problem	Lymphatic Filariasis (LF): Reduction of prevalence to below critical, sustainable thresholds, specifically: • Antigenaemia prevalence <2% in children aged 6–7 years (or in the general population, where applicable); • Microfilaria (mf) prevalence <1%; • Vector-specific thresholds: in Aedes-endemic areas, antigen prevalence <1%. Trachoma: • Active trachoma (TF): <5% prevalence of trachomatous inflammation–follicular in children aged 1–9 years; • Blinding trachoma (TT): <0.2% prevalence of unmanaged trachomatous trichiasis in adults aged ≥15 years, equivalent to approximately 1 case per 1,000 total population. Leprosy: • New case detection rate <1% case per 100,000 Rabies: • Zero human deaths from dog-mediated rabies; • Operational threshold: ≥70% of the dog population in a given area vaccinated annually for at least three consecutive years to interrupt transmission. Schistosomiasis (SCH): • <1% prevalence of heavy-intensity infections among school-aged children (SAC); • <10% disease prevalence among school-aged children (SAC). Soil-Transmitted Helminthiasis (STH): • <2% prevalence of moderate- and heavy-intensity (MHI) infections among school-aged children (SAC); • <20% disease prevalence among school-aged children (SAC).	LF, Trachoma (elimination dossier development and submission), Rabies, STH, SCH (national)
Control	Reduction of disease burden to acceptable levels, with ongoing interventions.	Mycetoma, Scabies, Podoconiosis, Tungiasis, Taeniasis, Cysticercosis, SBE

*Rwanda has targeted to pilot STH interruption in selected areas of two districts

3.2.1.1. National Strategic Goals and Disease Specific Targets

Accordingly, this strategic plan adopts four overarching goal categories in line with global targets, providing clear direction for NTD intervention over the planning horizon.

Table 10. National Goals and Disease Specific Targets

Strategic Goal	Specific Targets by 2030
Disease Eradication	✓ Submission of Yaws interruption of transmission verification dossier to WHO
Elimination (Interruption of Transmission)	✓ Onchocerciasis: ≥85% program coverage annually, 100% geographic coverage ✓ STH & SCH: Prevalence less than 1% qPCR in selected areas in 2 districts (Bugesera and Ruhango) ✓ Leprosy: zero new autochthonous cases among children (<5 years of age) for at least five consecutive years.
Elimination as a Public Health Problem	✓ SCH: Achieve a prevalence of <1% of heavy intensity infections and prevalence <10% among SAC in all IUs (Admin Cells). ✓ STH: Sustain national <2% prevalence of moderate and heavy intensity infections + a prevalence of <20% among SAC in IUs (Admin Sectors) ✓ Lymphatic Filariasis: Submit LF validation dossier by and achieve validation by 2030 ✓ Trachoma: Submit validation dossier by and achieve validation by 2030 ✓ Rabies: Achieve zero deaths due to dog-transmitted rabies
Disease Control	✓ Institutionalize case detection and clinical care for SBE, Mycetoma, Scabies, Tungiasis, Taeniasis, Podoconiosis and Cysticercosis ✓ Expand NTD data reporting into HMIS

3.2.1.2. Cross-Cutting Targets

To support achievement of disease-specific goals, Rwanda will pursue the following system-wide targets by 2030:

Table 11: Cross-Cutting Targets

Strategic Pillar	Cross-Cutting Target
Integrated Approaches	✓ 100% of primary healthcare facilities deliver integrated NTD services in line with the national NTD guideline ✓ At least 90% of schools conduct school-based deworming
Multisectoral Collaboration	✓ A fully functional multisectoral NTD coordination at the national level ✓ Streamlined WASH/NTD coordination in 100% of districts
Country Ownership	✓ NTDs integrated in health sector plans ✓ Key NTDs KPIs defined by MoH in collaboration with MINALOC, MINAGRI/RAB and integrated in district performance contracts ✓ Domestic NTD financing ≥70% ⁴ of national needs by 2030
Universal Health Coverage	✓ CBHI covers NTD morbidity management in line with the national NTD guideline.

⁴ Target benchmarked on the national financing target

3.2.1.3. Implementation Milestones Toward 2030 Disease-Specific Targets

To translate targets into action and monitor progress, annual milestones have been defined. These milestones track key outputs across all NTDs and ensure alignment with the strategic goal categories and timelines.

Table 12. Operational milestones toward the 2030 targets

Disease	2030 Target (from Table 10)	Milestone	2026	2027	2028	2029	2030
Yaws	Eradication / WHO certification	National eradication dossier finalized and submitted to WHO		✓			
		WHO review and validation process completed		✓	✓	✓	
		Certification of eradication achieved					✓
Onchocerciasis	Interruption of transmission / elimination	National mapping and transmission status assessment completed	✓			✓	
		Decision on MDA start/stop based on transmission status		✓			
		MDA implemented in confirmed transmission foci		✓	✓	✓	✓
Leprosy	Elimination as a public health problem	To reduce leprosy burden towards the interruption of decreasing the proportion of children among new leprosy cases from 12% in 2025 to 5% to 2030					✓
SCH/STH (subnational)	Morbidity control / elimination as a public health problem in targeted districts	Prevalence <2% in targeted districts achieved		✓			
		Threshold maintained through routine interventions and surveillance			✓	✓	✓
Lymphatic Filariasis (LF)	Sustain elimination / maintain prevalence <1% in all IUs	Prevalence <1% maintained in all IUs	✓	✓	✓	✓	✓
		Post-elimination surveillance strengthened and sustained		✓	✓	✓	✓
Trachoma	Elimination as a public health problem / WHO validation	Validation dossier prepared and submitted	✓				
		WHO validation achieved		✓			
		Post-validation surveillance and sustainability phase maintained			✓	✓	✓
Rabies	Zero human deaths from dog-mediated rabies	Annual zero dog-rabies mediated death is achieved and sustained					✓
		≥70% dog vaccination coverage sustained at all levels	✓	✓	✓	✓	✓
Snakebite Envenoming (SBE)	Universal access to antivenom at DHs and HCs	Baseline facility coverage established	✓				
		40% of facilities equipped with antivenom		✓			
		60% of facilities equipped with antivenom			✓		
		80% of facilities equipped with antivenom				✓	
		100% of facilities equipped with antivenom					✓
Mycetoma, Scabies, Tungiasis, Taeniasis, Cysticercosis	Integrated case management and surveillance in routine systems	National case management protocols adopted	✓				
		Surveillance and reporting integrated into HMIS		✓			
		Nationwide implementation and routine reporting sustained			✓	✓	✓

3.3. Guiding Principles

Table 13. Guiding principles

Guiding principles	1. National leadership and ownership 2. Equity and inclusion 3. Integrated and people-centered approaches 4. Collaboration and partnership 5. Community engagement and empowerment 6. Transparency, accountability, and results orientation 7. Resilience and sustainability 8. Innovation and learning
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3.4. Strategic Pillars and Objectives

3.4.1. Programme Strategic Pillars

Strategic Pillars are simply strategic areas the programme has to win to be successful. The below figure below illustrates programme strategic pillars.



Figure 7. Programme Strategic Pillars

3.4.2. Strategic Objectives

To achieve Rwanda’s NTD strategic goal of eliminating or controlling all endemic neglected tropical diseases by 2030, the programme is anchored on Four Strategic Pillars. Each pillar reflects a core priority area derived from national needs, WHO guidance, and stakeholder consultations. The following strategic objectives under each pillar define the high-level actions that will guide programme implementation, resource allocation, and partner alignment over the plan period.

Table 14. Strategic Objectives for the Elimination of NTDs

Strategic Pillar	Strategic Objectives
Pillar 1. Accelerating disease-specific interventions	Transition from vertical MDA campaigns to MDA embedded within decentralized routine primary health systems
	Pilot and scale up pediatric praziquantel (arPZQ) for preschool-age children
	Ensure 100% geographic coverage for MDA, where indicated.
	Scale-up and strengthen Morbidity Management and Disability Prevention (MMDP) services
	Complete and submit disease elimination dossiers and sustain elimination status.
	Enhance integrated early case detection, management and surveillance systems.
	Establish rapid outbreak response for epidemic-prone NTDs
	Implement integrated vector surveillance and control interventions.
	Empowering districts and health facilities in endemic and non-endemic zones to organize and conduct leprosy case-finding campaigns
Pillar 2. Strengthening cross-cutting and Integrated approaches	Mainstream integrated NTD services into PHC, school health, and WASH platforms
	Operationalize One Health collaboration for zoonotic and vector-borne NTDs (targeting rabies, SBE, rHAT, cysticercosis/taeniasis, SCH and others with cross-sector response mechanisms).
	Expand the reporting of NTD indicators into national HMIS/DHIS2 systems
	Strengthen joint community-based delivery of interventions for NTDs (with coordination among CHWs, SBC programs, local government, and WASH sector)
	Integrate NTD diagnostics, training, and quality control into existing disease programs by leveraging existing resources.
	Strengthen national and subnational human resource capacity for NTD planning, delivery, monitoring and supervision
Pillar 3. Enhancing systems, capacity, and country ownership	Institutionalize NTD accountability mechanisms within decentralized governance structures (Integrate NTD indicators and responsibilities into district performance contracts and local health governance frameworks)
	Establish routine and integrated supportive supervision and monitoring systems for all NTD interventions.
	Strengthen the supply chain and logistics system for NTD medicines, diagnostics.
	Promoting socio-economical inclusion of NTD-affected persons
	Enhance institutional capacity of the NTD Program for coordination, planning, and multisectoral engagement.
	Mobilize domestic financial resources to cover at least 70% (in line with HSSP V) of the national NTD program budget by 2030.
Pillar 4. Sustainable Financing and Partnerships	Coordinate and align implementing partners around national NTD priorities and activity plans.
	Engage the private sector in NTD program planning, financing and delivery.
	Institutionalize multisectoral coordination platforms at national and district levels.

3.4.2.1. Program Strategic Agenda Logic Map

The following logic map illustrates how Rwanda's NTD program components—mission, vision, strategic pillars, and strategic objectives—are interlinked to deliver on the national and global targets for NTD elimination by 2030. It provides a visual summary of the program's strategic architecture in line with the WHO Thirteenth General Program of Work (GPW 13) ⁴⁵

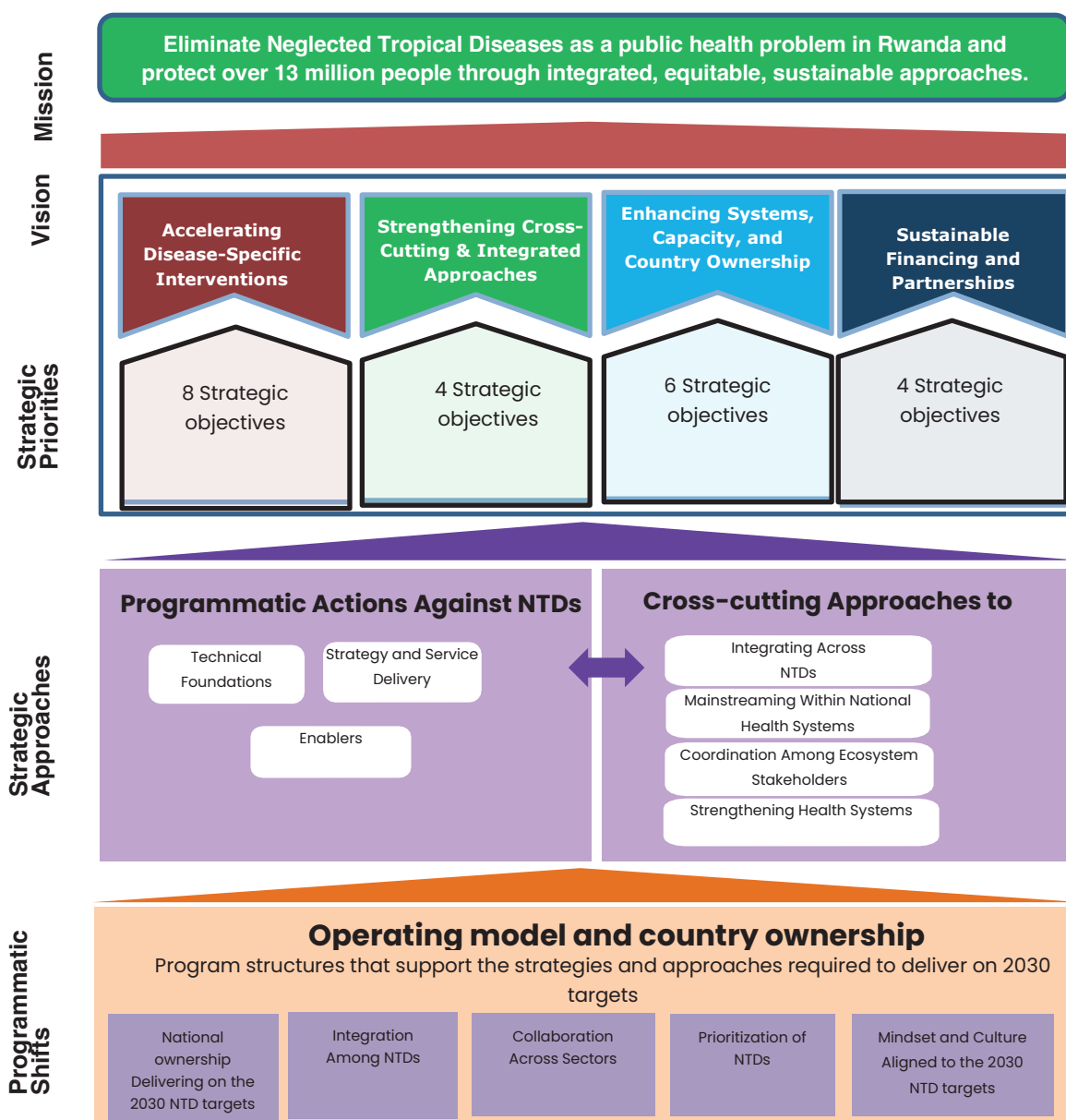


Figure 8. Program Strategic Agenda Logic Map Template

⁵ WHO. Thirteenth General Programme of Work 2019–2023. Page 4. Available <https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>

4. Implementing the Strategy: NTD Operational Framework

This strategic plan aims to advance Rwanda's efforts against NTDs by delivering four key strategic goals presented earlier. Achieving these goals requires a shift in how NTD services are delivered, measured, and owned. This plan embraces three transformative shifts:

- **A focus on measurable impact** through outcome-based indicators aligned with global validation and certification standards;
- **Greater integration within the national health system**, with NTD services mainstreamed into PHC, school health, WASH, and One Health platforms;
- **Enhanced national leadership and ownership**, through strengthened governance, financing, and decentralization mechanisms.

To translate these shifts into action, Rwanda's NTD program will implement coordinated initiatives under four strategic pillars. Each pillar is anchored by specific objectives and implemented through time-bound strategic activities and clearly defined resource needs. These are designed not only to achieve Rwanda's national targets but also to ensure that NTD interventions are sustainable, equitable, and embedded within broader health and development systems.

4.1. Strategic Objectives and Activities

The following strategic activities are structured under the four pillars and aligned with Rwanda's national goal categories. Each activity contributes to one or more of the national objectives across the four strategic goals, and supports cross-cutting areas such as health systems strengthening, community engagement, and multisectoral collaboration.

4.1.1. Accelerating disease-specific interventions

Despite strong national achievements in mass drug administration (MDA) and high treatment coverage, the 2024 program review identified several gaps that threaten progress toward national elimination and control goals. These include limited therapeutic coverage among adults, persistent subnational high prevalence of STH and SCH, and uneven access to morbidity care for diseases such as podoconiosis, leprosy, rabies, and snakebite envenoming. Implementation of onchocerciasis elimination will be guided by a dedicated National Onchocerciasis Elimination Plan, developed following confirmation of ongoing transmission and aligned with the broader NTD Strategic Plan. Furthermore, rabies elimination will be guided by the National Rabies Elimination Strategy 2026-2030.

Additionally, for diseases approaching or eligible for elimination status, such as LF, trachoma, yaws, and onchocerciasis—focused efforts are needed to complete validation dossiers, verify transmission interruption, and sustain post-elimination surveillance. The ongoing transition from MDA campaign to routine deworming also calls for system-wide changes to ensure sustainable delivery and monitoring.

This pillar consolidates Rwanda's disease-specific interventions under eight strategic objectives. These range from completing elimination pathways and expanding morbidity care to strengthening case detection, initiating outbreak response, and sustaining vector control. Collectively, these efforts will accelerate Rwanda's trajectory toward NTD elimination and ensure sustained impact across all targeted diseases.

Table 15. Strategic Objectives and activities under pillar 1

Strategic Objective	Strategic activities	Time frame	Resources needed
Strategic objective 1: Transition from vertical MDA campaigns to MDA embedded within decentralized routine health systems.	Update national guidelines and standard operating procedures (SOPs) for school- and community-based routine deworming, integrated into primary health care (PHC) and school health programs.	2026	Technical working group, policy experts, stakeholder consultations
	Conduct refresher training for PHC providers, community health workers (CHWs), and school health staff on routine mass drug administration (MDA) protocols.	2026–2027	Trainers, training materials, logistics support, budget
	Ensure continuous supply of deworming medicines through national drug supply chain systems.	2026–2030	Procurement plan, forecasting tools, logistics and distribution funding
	Monitor MDA coverage, uptake, and adverse events using routine data systems (cEMR, HMIS, school reports, and other relevant tools).	2026–2030	M&E tools, training in data reporting, digital integration support
Strategic objective 2: Ensure 100% geographic and recommended effective coverage for MDA where indicated	Revise the MDA strategy across all implementation units (IUs) based on updated disease prevalence data.	2027	Technical teams and financial resources.
	Strengthen microplanning and logistical coordination at the sector level.	2026–2030	Trained local microplanning teams and logistics
Strategic Objective 3: Scale-up and strengthen Morbidity Management and Disability Prevention (MMDP) services	Conduct national mapping of morbidity burden for podoconiosis, snakebite envenoming (SBE), and other relevant NTDs	2026–2028	Field data collection teams, diagnostics, GIS mapping tools, morbidity survey tools, budget for field logistics
	Integrate MMDP packages into PHC services (provider training, job aids, and care pathways).	2026–2027	Clinical training materials, trainers, PHC staff, SOPs/job aids, supervision tools
	Develop an integrated Morbidity Management and Disability Prevention (MMDP) guideline for targeted NTDs, including associated mental health care.	2027–2028	Technical teams and logistics
	Scale up access to essential morbidity care services (e.g., hygiene kits, footwear for podoconiosis, antivenom) and integrate them into primary care.	2026–2030	Procurement systems, storage and distribution support, medical supplies, community education materials
	Monitor MMDP uptake and outcomes via HMIS integration	2026–2030	HMIS/DHIS2 integration tools, EMR, other digital forms, trained data officers, IT system upgrades
Strategic Objective 4: Complete and submit disease elimination dossiers, and sustain elimination status.	Establish NTD elimination committees (MoH-appointed).	2027	ToR, technical teams, logistics
	Compile and update national data for elimination dossier development (LF, trachoma, yaws, schistosomiasis, leprosy)	2026–2027	Data officers, program focal persons, HMIS records, TA for dossier standards
	Develop and submit elimination dossiers to WHO for validation or certification	2026–2028	Dossier consultants, technical review workshops, national validation taskforce, translation/printing
	Establish post-validation surveillance systems for diseases with confirmed elimination	2028–2030	Surveillance protocols, training, reporting tools, integration into HMIS, community case detection training

Strategic Objective	Strategic activities	Time frame	Resources needed
Strategic Objective 5: Enhance integrated early case detection, management and surveillance systems	Develop and disseminate national guidelines and SOPs for NTD case detection and surveillance (all target diseases)	2027-2028	Technical working groups, consultants, printing/distribution
	Train CHWs and facility staff on integrated case definitions and detection protocols	2026–2027	Training facilitators, modules, venue, per diem, supervision teams
	Introduce and scale community-based active case finding for skin NTDs.	2026–2028	CHWs, diagnostic kits, case referral tools, health center engagement
	Integrate routine NTD reporting indicators into DHIS2 and strengthen data review/feedback cycles at district and facility level	2026–2027	DHIS2 developers, data officers, laptops/tablets, M&E specialists
	Conduct quarterly district-level NTD data review and feedback meetings integrated with other health programs	2026–2030	District facilitators, transport, meeting costs, supervision checklists
	Integrate new NTD medicines and diagnostic tools into the revised health facility minimum package and list of essential medicines.	2026-2027	Technical teams to update NTD guideline, logistics
'Strategic Objective 6: Establish rapid outbreak response and reporting for epidemic-prone NTDs	Develop and institutionalize national outbreak response protocols and contingency plans for NTDs (e.g., scabies, rabies)	2027	Technical working group, policy consultants, printing
	Integrate NTDs into the Risk Communication and Community Engagement Strategy (RCCE)	2027	TA, Technical teams, logistics
	Train district and facility-level rapid response teams (RRTs) on detection, reporting, and containment of NTD outbreaks	2026–2027	Trainers, SOPs/manuals, per diem, training venues
	Establish multi-sectoral coordination mechanisms for outbreak-prone zoonotic NTDs (including health, agriculture, animal health)	2026–2028	Coordination meetings, MoUs, transport, TA
	Conduct simulation exercises and after-action reviews to test readiness and refine response systems	2026–2030	Monitoring team, evaluation tools, facilitation costs
Strategic Objective 7: Implement integrated vector surveillance and control interventions.	Develop and disseminate national vector control guidelines for NTDs integrated with other programs.	2027	Technical working group, printing and distribution, policy development support
	Conduct entomological assessment for targeted NTDs.	2026–2029	Entomology teams, mapping tools, technical assistance, data systems
	Integrate and implement NTD activities within existing vector control interventions.	2026–2030	Insecticides, coordination meetings, community health agents, technical guidelines
Strategic Objective 8: Empowering districts and health facilities in endemic and non-endemic zones to organise and conduct leprosy case-finding campaigns	Organise and conduct ACF campaigns, home visits and contact tracing in leprosy-endemic areas	2026–2030	Funds transfer, monitoring tools, MoUs, Transport
	Conduct information and educational activities at the HFs, refugee camps and schools.	2026–2030	Transferring the funds, technical guidelines, MoUs, Transport,
	Provide preventive materials of disabilities (sandals or slipper/pantoufles) and material for	2026–2030	MoUs, Surgeons, materials procurement

Strategic Objective	Strategic activities	Time frame	Resources needed
	care (basin, bandages, etc.) to patients. (MMDP)		
	Ensure that people with leprosy-associated conditions are assisted with assistive tools (wheelchairs, walking sticks, glasses)	2026–2030	MoUs, Surgeons, meetings with bodies in the field
	Maintain good drug management practices and keep stock cards updated at all levels.	2026–2030	Stock monitoring, monitoring tools
	Integrate quantification of leprosy products in the Coordinated Procurement and Distribution System (CPDS) and in national health needs.	2026–2030	Coordination meetings, monitoring tools
	Ensure the first dose is dispensed to patient under direct supervision, preferably at the HC, to prevent rifampicin resistance	2026–2030	Monitoring tools
	Reinforce active drug safety monitoring.	2026–2030	Monitoring tools, monthly mentorship
	Ensure regular availability of Single-Dose Rifampicin (SDR) for all cases of leprosy contacts detected and a reserve stock in district pharmacies in endemic area.	2026–2030	Meeting, monitoring tools
	Collaborate with surgeons to train patients and FPs with G2D how to care for wounds and ulcers, and provide the self-care manual	2026–2030	Coordination meetings, venues, per diem and transport
	Conduct ACF and contact investigation in districts having reported at least one leprosy case in the last 5 years (in villages) with the collaboration of the DH, HC, and CHW.	2026–2030	Per diem, transport, meetings
	Involve former leprosy patients in ACF and contact tracing and awareness campaigns	2026–2030	Incentives, meetings
	Advocate for the inclusion of leprosy-related activities in districts NSPs with endemic and zones with sporadic cases.	2026–2030	Transport, Per diem, coordination meetings
	Update the leprosy treatment guidelines	2026–2030	Coordination meetings, venues, per diem and transport

4.1.2. Strengthening cross-cutting and integrated approaches

Persistent challenges such as fragmented service delivery, limited WASH and One Health integration, inadequate surveillance, and residual stigma continue to constrain the reach and equity of NTD interventions in Rwanda. The mid-term program review highlighted critical missed opportunities to embed NTD services within national platforms such as primary health care (PHC), school health, community health worker (CHW) systems, WASH infrastructure, and cross-sector coordination mechanisms. It also noted that despite progress, surveillance remains siloed and underutilized for early detection, response, and program monitoring.

This pillar responds to these gaps by advancing integrated and cross-sectoral approaches that align with national systems and global commitments. Strategic activities under this pillar aim to mainstream NTD services into PHC, school health, and WASH platforms; strengthen digital surveillance through HMIS/DHIS2, EMR; enhance joint community-based delivery through CHWs and local government; and

operationalize One Health collaboration for zoonotic and vector-borne NTDs such as rabies, cysticercosis, and SBE. These efforts will build a more resilient and efficient delivery system, improve early detection and response, and ensure that NTD services reach underserved populations through sustainable and people-centered pathways.

Table 16. Strategic Objectives and activities under pillar 2

Strategic Objective	Strategic activities	Time frame	Resources needed
Strategic Objective 1: Mainstream integrated NTD services into PHC, school health, and WASH platforms	Integrate NTD case management into PHC service packages and clinical guidelines.	2026–2030	Policy revision support, clinical guideline developers, training facilitators, printing costs
	Integrate NTD programming into higher learning health institutions' curricula	2027–2028	Training material, facilitators and logistics.
	Conduct training for PHC providers, school health workers, and WASH teams on integrated NTD management and prevention	2026–2030	Trainers, training materials, per diem, logistics support, training venues
	Integrate NTD interventions (e.g., deworming and health education, awareness) into school health program implementation.	2026–2030	MDA medicines, coordination with education sector, M&E tools
	Conduct regular joint reviews of NTD and WASH data to inform decision-making.	2026–2030	WASH–NTD technical working group support, joint planning forums, IEC materials
	Monitor service uptake and quality of integrated NTD delivery in PHC and schools	2026–2030	Supervision teams, M&E tools, integration into DHIS2/EMR, transport
Strategic Objective 2: Operationalize One Health collaboration for zoonotic and vector-borne NTDs	Streamline NTD intervention programming through the One Health approach (joint planning, workshops, SOPs, and joint training).	2026–2028	Coordination sessions, legal/policy advisors, inter-ministerial meetings, documentation tools
	Develop and implement joint outbreak response protocols for zoonotic and vector-borne NTDs	2026–2028	Technical teams, protocol drafting workshops, simulation exercises, printing
	Conduct joint surveillance and reporting for zoonotic and vector-borne NTDs using interoperable systems	2026–2030	IT systems alignment, training for human/veterinary sectors, data sharing platforms
	Address zoonotic NTDs using joint animal-human-environment health education campaigns.	2026–2030	IEC/BCC materials, media airtime, school curricula revision, CHW and community vet engagement
	Train frontline workers (health and veterinary) on early detection and response to zoonotic and vector-borne NTDs	2026–2028	Trainers, training manuals, venue and logistics, per diem, veterinary and human health trainers
Strategic Objective 3: Review and integrate NTD indicators and reporting into national HMIS/DHIS2 systems	Review existing NTD indicators and define priority indicators for HMIS/DHIS2 integration	2027	Technical working groups, M&E specialists, facilitation costs, meeting logistics
	Train district- and facility-level health workers on NTD data entry, reporting, and use of HMIS tools	2026–2028	Trainers, training manuals, ICT support, supervision costs, venue and logistics
	Conduct joint quarterly data quality assessments (DQAs) and feedback sessions for NTD reporting	2027–2030	DQA tools, field visits, M&E staff time, report templates, feedback materials
	Integrate NTD data into national health sector performance dashboards	2027–2030	Analytics consultants, data visualization tools, report integration support
	Organize an integrated annual stakeholders' meeting to review NTD	2026–2030	Teams, workshop facilities, logistics

Strategic Objective	Strategic activities	Time frame	Resources needed
	program performance and prioritization		
Strategic Objective 4: Strengthen joint community-based delivery of interventions for NTDs (with coordination among CHWs, local government, and WASH sector)	Develop and update national guidelines for integrated NTD service delivery at community level	2026–2028	Technical consultants, review workshops, MoH and RBC coordination, printing and dissemination budget
	Train CHWs and primary health workers on integrated NTD service delivery	2026–2028	Training materials, facilitator teams, community venues, job aids, per diem and transport
	Strengthen and engage with existing intersectoral coordination forums at district level involving WASH, local govt, CHWs, and education.	2026–2028	Meeting logistics, district focal points, transport, planning tools
	Engage CHWs and cured persons affected by skin NTD to participate in patient follow up	2026–2030	Meeting logistics, incentives, transport, planning tools
	Provide national guidance on district-led integrated community and household outreach for NTD prevention	2026–2030	CHW incentives, IEC materials, supervision support, water and sanitation messaging supplies
	Conduct integrated supportive supervision of community-based NTD services and collect feedback.	2027–2030	Supervision teams, checklists, M&E support, reporting formats

4.1.3. Enhancing systems, capacity, and country ownership

Rwanda’s ability to eliminate NTDs by 2030 and sustain those gains depends on a resilient, decentralized, and well-integrated health system. The 2024 program review revealed persistent gaps in core systems functions—namely, inadequate human resources at subnational levels, weak integration of NTDs into district planning and health information systems, insufficient supervision and performance monitoring, and recurring stockouts of essential NTD medicines and diagnostics. These gaps undermine the country’s progress toward its elimination and morbidity control targets.

This pillar prioritizes the institutionalization of NTD interventions within the broader health system and aligns with national strategies for decentralization and universal health coverage (UHC). Strategic actions focus on building local ownership, expanding workforce capacity, strengthening supply chains and supervision systems, and embedding NTD accountability within district performance contracts (Imihigo). These efforts will ensure that NTD services are not only scaled up but sustainably managed and delivered through existing health infrastructure, laying the foundation for long-term program resilience, equity, and efficiency.

Table 17. Strategic Objectives and activities under pillar 3

Strategic Objective	Strategic activities	Time frame	Resources needed
Strategic Objective 1: Enhance institutional capacity of the NTD Program for coordination, planning, and multisectoral engagement	Strengthen the operational effectiveness of the NTD Sub-Technical Working Group through quarterly meetings.	2026–2030	Meeting facilitation, technical experts, coordination budget, TOR development
	Develop a multi-year NTD sustainability and resource mobilization strategy aligned with the current NTD strategic plan.	2027	Planning workshops, consultancy support, costing tools, data inputs
	Institutionalize annual joint planning and review sessions with subnational and sectoral stakeholders	2026–2030	Review meeting costs, participation support, planning templates, reporting tools
	Build the capacity of FPs /ToTs/MDs on leprosy and other skin NTDs to involve in capacity building for fellow	2027–2030	Training venues, per diem, transport

	HCPs		
	Strengthen the NTD program by reinforcing existing human resources and strategically recruiting additional technical expertise in M&E, Data management, supply chain, and advocacy.	2026–2029	Staff recruitment/secondment, orientation, capacity building, operational budget
	Capacity building and raising leprosy awareness for local leaders, youth organisation, teachers, and faith-based organisation in endemic zones	2027-2030	Meeting logistics, district focal points, transport, planning tools
	Develop a disability inclusive Information, Education, and Communication	2027-2030	Meeting logistics, district focal points, transport, planning tools
Strategic Objective 2: Strengthen subnational human resource capacity for NTD planning, delivery, monitoring and supervision.	Work with MINALOC to designate NTD focal points from existing staff at district level to drive district-wide NTD priorities	2027	Policy endorsement, staffing budget, TORs, coordination with HRH planning
	Integrate NTD responsibilities into district health team performance frameworks (Imihigo)	2026–2030	Technical support, alignment workshops, planning templates
	Develop e-Learning course on NTDs	2026-2030	Technical support, alignment workshops, planning templates
	Organise mentorship visits from RBC to DHs and HCs in collaboration with Rwanda Dermatologist association in skin NTDs endemic and non-endemic areas.	2026-2030	Per diems, transport meeting costs, participation support, planning templates, reporting tools
Strategic Objective 3: Institutionalize NTD accountability mechanisms at the national and decentralized governance structures	Develop a multisectoral collaboration and accountability framework for NTD control, advocacy, communication and financing.	2027	Consultant, logistics, technical teams/workshops, Media materials, stakeholder mapping, campaign funding, technical writing support
	Integrate NTDs into existing reporting systems and decentralized data review, validation, and accountability mechanisms.	2026–2027	Technical support, data flow tools, meeting logistics, district coordination
Strategic Objective 4: Ensure quality NTD service delivery through integrated routine and integrated supportive supervision and monitoring systems for all NTD interventions	Develop and standardize national NTD supportive supervision tools across diseases and platforms	2027	Technical expertise, design workshops, stakeholder validation sessions
	Integrate NTD indicators and checklists into existing health sector supportive supervision plans, where appropriate.	2027	Coordination with HMIS/M&E units, printing of updated tools, orientation meetings
	Train district and facility supervisors on integrated NTD supervision tools and approaches	2026–2027	Training materials, facilitators, venue/logistics support, per diem
	Integrate NTD quality control (QC) into laboratory protocols and supervision visits at all relevant levels.	2026–2030	QA forms, lab personnel, supervision checklists, operational funds
	Conduct targeted mentorship supportive supervision visits on NTD management.	2026–2030	Supervision tools, transport, supervision budget, central and district-level staff time
	Adapt IEC tools into simple and appropriate language for education of patient with leprosy	2026-2030	IEC tools, facilities-level staff time, consultant
Strategic Objective 5: Strengthen the supply chain and logistics system for NTD medicines, diagnostics	Conduct national quantification and forecasting of NTD medicines, diagnostics, and supplies	2026-2030	Forecasting tools, national & district logistics data, quantification workshops, technical support
	Strengthen last-mile delivery and	2026–2030	Delivery vehicles/support, fuel,

and commodities.	monitoring mechanisms and reduce stock outs at facility level		supervision allowances, coordination meetings
Strategic Objective 6; Strengthen NTD research capacity in collaboration with relevant programs and research institutions.	Define priority NTD research questions to inform policy and program decision-making.	2026–2030	Workshops and logistics
	Identify funding opportunities and develop and submit competitive research grant proposals.	2026–2030	Workshops and logistics
	Implement prioritized NTD research projects in collaboration with partner institutions.	2026–2030	Technical teams, workshops for analysis/protocol refinement, data collection and logistics.
	Disseminate and translate research findings to inform policy, programming, and practice.	2026–2030	Travel, workshop, publication processing charge
	Implement sentinel site surveillance for STH and schistosomiasis drug efficacy and emerging resistance to inform national and global monitoring efforts.	2027–2030	Technical teams, workshops, field activities

4.1.4. Sustainable financing and partnerships

Achieving Rwanda's 2030 NTD targets will require a resilient and self-sustaining program with diversified and well-coordinated funding and collaboration mechanisms. The 2024 program review highlighted that while Rwanda has made important strides, the NTD program remains highly dependent on external funding—domestic contributions covered only 2.3% of total NTD expenditures in 2022/2023—posing a serious risk to long-term sustainability. In addition, partner support remains fragmented, particularly at the subnational level, and critical coordination with sectors like education, WASH, animal health, and emergency response is underleveraged.

This pillar addresses these gaps by focusing on mobilizing increased domestic and innovative financing, strengthening the alignment and coordination of external support with national priorities, and reinforcing multisectoral collaboration platforms. It emphasizes institutional mechanisms to track funding flows, increase accountability, and promote shared ownership across public, private, and civil society actors. By embedding financing and partnerships within national systems and planning processes, Rwanda can enhance the sustainability, equity, and responsiveness of its NTD response—ensuring that no district or population is left behind as the country accelerates toward its elimination and control goals by 2030.

Table 18. Strategic Objectives and activities under pillar 4

Strategic Objective	Strategic activities	Time frame	Resources needed
Strategic Objective 1: Mobilize domestic financial resources to cover at least 70% (in line with HSSP V) of the national NTD program budget by 2030	Conduct the analysis of the implementation of the NTD annual plan to assess performance and financing gaps to guide planning.	2026-2030	MoH planning unit, technical assistance
	Advocate for increased government budget allocations for NTDs.	2026–2027	Planning and budgeting officers, district health management teams, costing tools
	Advocate for the introduction of NTD budget lines into district health plans.	2026–2027	Meetings, logistics
	Engage Parliament, Ministry of Finance, and civil society in high-level advocacy for NTD financing	2026–2030	Policy briefs, advocacy champions, logistics for meetings, media
	Track and publicly report domestic contributions to NTDs annually	2026–2030	M&E staff, financial tracking systems, data visualization tools
Strategic Objective 2: Coordinate and align implementing partners	Widely disseminate the NTD Strategic Plan and other accompanying key documents ensure their official	2027	Workshop & logistics, printing

Strategic Objective	Strategic activities	Time frame	Resources needed
around national NTD priorities and activity plans.	transmission to key relevant sectors		
	Conduct biannual national partner meetings to review implementation progress and align plans.	2026–2030	Meeting logistics, facilitator teams, MoH coordination staff, reporting tools
	Establish a digital dashboard or platform to track stakeholder contributions, activities, and geographic coverage	2026–2027	IT developers, DHIS2 integration experts, data management staff, hosting infrastructure
	Integrate partner activities into the national annual NTD work plan and budget process	2026–2030	Planning officers, NTD program team, consolidated calendar and templates
	Organize a workshop with all administrative stakeholders for dissemination of NTD SP 2026-2030	2026-2030	Workshop materials, facilitators, venue/logistics support, per diem
Strategic Objective 3: Engage the private sector in NTD program planning, financing and delivery	Map and profile potential private sector partners by area of action (e.g., logistics, technology, media, pharmaceutical companies such as Merck and GSK, and CSR).	2027	Consultant support, MoH focal points, private sector liaison
	Partner with telecom and media companies for digital/social mobilization	2026–2030	SBC materials, media slots, community radio airtime, digital platform access
	Explore innovation challenge funds and submit applications to test and scale up NTD solutions and tools in Rwanda.	2026–2030	Technical teams, innovation coordination, grant applications
	Advocate for more emphasis on Skin NTDs including leprosy in academic training of nurses and medical doctors.	2026-2030	Technical teams, workshops
	Conduct collaborative outreach with Rwanda Dermatology Association on skin conditions in leprosy endemic areas.	2027-2030	logistics, district focal points, transport, facilitators incentives, planning tools
Strategic Objective 4: Ensure strengthened local NTD governance platforms at the district level.	Ensure wide dissemination of national multisectoral coordination guidelines for NTD	2026–2028	Printing, dissemination events, media

4.2. Toward Program Sustainability: Intensifying Coordination and Partnerships

Sustaining the progress made in NTD elimination and control requires not only scaling up interventions but also embedding them into broader national systems. This section outlines how the Rwanda NTD program will transition toward greater sustainability by intensifying coordination across government sectors, integrating services into existing health and development platforms, and increasing domestic investment. Building on the strategic pillars and activities already defined, Rwanda will strengthen governance, institutional capacity, and multisectoral collaboration—ensuring that NTD services are no longer delivered as vertical programs, but as part of a resilient and inclusive national health system.

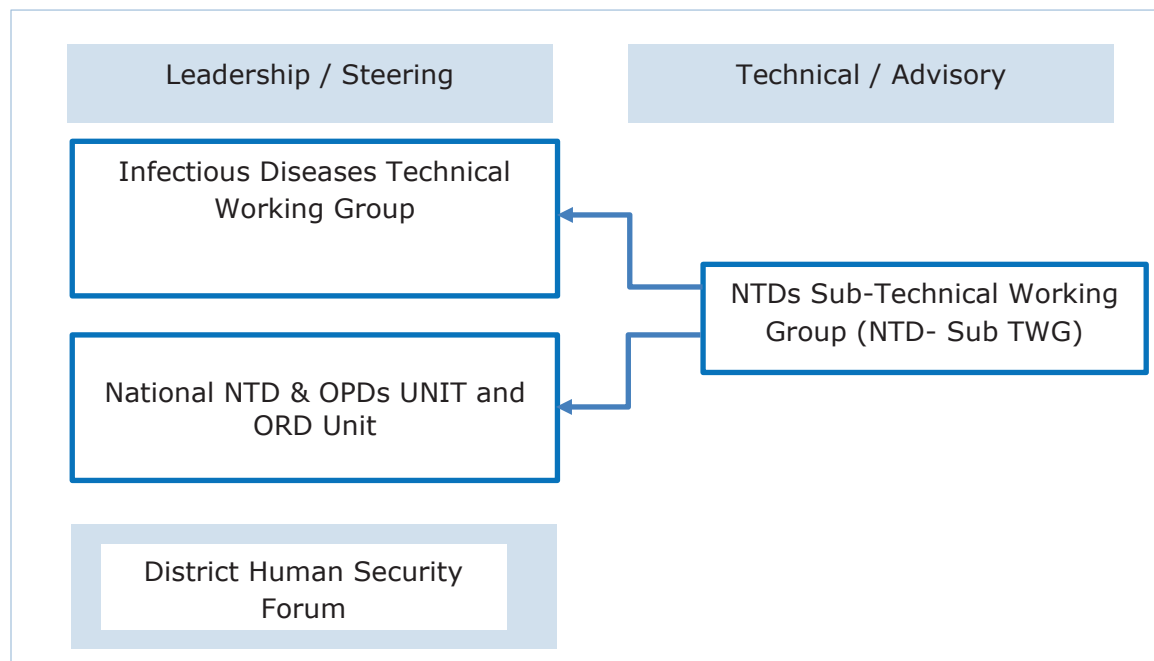


Figure 9. Program coordination mechanism

Rwanda's coordination structure for NTDs is designed to ensure technical oversight, multisectoral collaboration, and alignment with national health priorities. It integrates leadership, technical advisory, and operational implementation roles across governance levels, enabling a cohesive and sustainable response to NTDs.

At the national level, the **Infectious Diseases Technical Working Group (ID-TWG)** provides overall leadership and strategic direction. The **NTD Sub-Technical Working Group (Sub-TWG)** serves as the technical and advisory platform supporting this leadership, chaired by the Director of the NTD and OPD Unit at RBC, with co-chair representation from WHO and alternate leadership from UNICEF and the Ministry of Health. Composed of government institutions, development partners, civil society, and private sector stakeholders, the Sub-TWG guides technical support, harmonization of partner inputs, and alignment of national strategies through a Joint Action Plan.

The NTD Sub-TWG meets quarterly and coordinates across sectors to translate national objectives into implementation frameworks. This includes technical assistance, joint field visits, capacity-building, and policy alignment to accelerate NTD control and elimination.

The **National NTD & OPDs Unit together with the ORD Unit**, based at RBC, acts as the operational engine of the coordination system. It ensures execution of programmatic activities, liaises with partners, oversees reporting, and provides supervision and support to decentralized actors. The Unit also channels guidance between the Sub-TWG and higher-level decision-making forums.

Leprosy control is integrated at the different levels of the health services. ORD Unit, one of four units of the TB&ORD Division, has the responsibility of conceiving, directing and coordinating leprosy control activities while providing technical support and necessary resources. Under the authority of the Division Manager, the Leprosy Senior Officer is directly responsible for leprosy control tasks and are supervised by the ORD unit Director. At peripheral level, leprosy is integrated in the minimum package of activities of HF and usually assigned to the TB focal point (FP).

At the **district level**, NTD-related issues are increasingly addressed through the **District Human Security Forum**—a multisectoral platform originally designed to coordinate responses to broader human security

concerns. While not established specifically for NTDs, this forum has naturally become a venue for addressing NTD-linked challenges, including access to water and sanitation, disability, animal health, and health equity. To enhance its effectiveness in this area, it is proposed that an NTD focal point be designated within the Forum. This will improve visibility, ensure consistent follow-up of NTD priorities, and link district action with national strategic goals.

The purpose of this coordination structure is to enable an integrated, results-oriented approach to NTD elimination in Rwanda—transitioning from vertical programming to embedded, system-based solutions sustained by national and local ownership. Additionally,

Table 19. Program Coordination Mechanisms and Membership

Entity	Membership	Terms of Reference
Infectious Diseases Technical Working Group		
Meeting frequency: Biannual Chair: HIV/AIDs, Diseases Prevention and Control Department Host: RBC	MoH and Government agencies, development partners, academia, research institutions, NGOs and Civil Society Organization (CSO)	Provides technical support to the Neglected Tropical Diseases and Other Parasitic Diseases (NTD&OPD) within the Rwanda Biomedical Center (RBC)/Ministry of Health; related to planning, implementation, and monitoring of NTD control and elimination interventions.
NTD & OPDs Unit & ORD Unit		
Meeting frequency: Monthly internal reviews, ad hoc as required Chair: Director, NTD & OPDs Unit, RBC Host: Rwanda Biomedical Centre	Technical staff of NTD and ORD Units, Program focal points, and Partner embedded staff	Leads national-level planning, implementation, supervision, M&E, and partner coordination on all NTD activities.
NTD Sub-Technical Working Group		
Meeting frequency: Quarterly (last Thursday); Core team meets monthly or as needed Chair: Director, NTD and Other Parasitic Diseases Unit (RBC) Host: Hosted by RBC and rotated among partners	AKROS/RBC, CHAI, CHUB (2), CHUK (2), ECD, END Fund, FAO, GISAGARA (2), Gakenke team, Gasabo district, Gasabo/ Kacyiru DH, HASA, Kibagabaga DH, MCCH Division, MIGEPROF, MINAGRI (2), MINALOC (2), MINEDUC, MINENV, MININFRA, MoH/ EH, MoH/ M&E, NCPD, NYAMASHEKE (3), PSF, RAB (4), RBC (4), RBC/ TB&ORD, RBC/Community Health, RBC/Disability, RBC/Epi, RBC/Finance, RBC/NRL (3), RBC/RHCC, RCA, RCS, RDB (2), REB, REMA, RFDA, RNP, RWB, Remera HC Team, Rusizi team, Rwamagana (2), SFH, UGHE, UNHCR, UNICEF, UR (4), UR-CMHS, UR/CAVM, WAG, WASAC, WFP, WHO, WHO/ CHE, WHO/ Communication, WV, Water Aid	Coordinates NTD program implementation, monitors progress, supports districts, aligns stakeholders, and develops Joint Action Plan.
District Task Force of Human Security Issues		
Meeting frequency: Quarterly Chair: Mayor of the District Host: District/s	District-level leaders (health, education, agriculture, security organs, civil society)	Multi-sectoral forum for addressing Humana security issues including WASH, hygiene, and disease prevention. Can be leveraged for NTD awareness, advocacy, and coordination.

4.3. Assumptions, risks and mitigations

The table below outlines key risks that could affect the successful implementation of Rwanda's NTD Strategic Plan. For each risk, the likelihood and potential impact are assessed before and after applying mitigation measures. Risks are also categorized by type, and clear mitigation strategies are proposed to reduce their negative effects. This approach ensures that assumptions are continuously tested, risks are proactively managed, and corrective actions are embedded into the programme cycle.

Table 20. Risk Criteria and Assessment

Risk Type	Likelihood (Before)	Impact (Before)	Score (Before)	Mitigation Strategy	Likelihood (After)	Impact (After)	Score (After)	Risk Rating
Risk Type: Financial / Programmatic								
Insufficient domestic financing for NTDs	4	4	16	Mobilize domestic resources; advocate through MoH and Parliament	3	3	9	Moderate
Risk Type: Institutional / Programmatic								
Insufficient coordination among partners	4	3	12	Institutionalize quarterly coordination meetings and joint planning	2	2	4	Minor
Risk Type: Supply Chain / Operational								
Stockout of essential NTD medicines	5	4	20	Improve forecasting and procurement processes; buffer stock	3	2	6	Minor
Risk Type: Community / Social Behavioral								
Low community uptake of MDA especially older age groups	3	5	15	Enhance SBC campaigns; use CHWs	2	3	6	Minor
Risk Type: Programmatic / Technological								
Limited surveillance and data integration	4	3	12	Upgrade HMIS/DHIS2 and train health staff	2	2	4	Minor

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

Table 21: 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

4.4. Performance and Accountability Framework

To ensure effective delivery of the updated NTD Strategic Plan and achievement of the 2030 national and global targets, this section presents an enhanced performance and accountability framework structured around the four strategic pillars. It reflects the evolving priorities of the Rwanda NTD program—emphasizing results, data use, decentralized accountability, and cross-sectoral integration.

For each strategic objective, the framework defines specific, measurable indicators with intermediate and endline targets. These indicators are aligned with the WHO *Compendium of NTD Indicators*, ensuring harmonised definitions for numerators, denominators, data sources, and frequencies of data collection. This alignment enables comparability across time, facilitates integration with global reporting requirements (including WHO's Global NTD Annual Reporting Form), and supports interoperability with national systems such as DHIS2 and the National Health Intelligence Center (NHIC).

4.4.1. Data Quality Assurance

Robust data quality is central to performance monitoring. The framework adopts WHO's four recommended data quality dimensions:

- **Completeness & Timeliness** – tracking the proportion of expected reports submitted on time;
- **Internal Consistency** – verifying coherence of reported data across time periods and indicators;
- **External Consistency** – triangulating program data with surveys, logistics data, and special studies; and
- **Population Data Consistency** – validating denominators against census and demographic projections.

Routine data quality assessments (DQAs) will be conducted semi-annually and at midterm, with results shared through quarterly data review meetings and supportive supervision visits. Findings will be used to identify reporting gaps, provide targeted mentorship to facilities and districts, and update program tools as needed.

4.4.2. Monitoring, Reporting, and Use of Data

Progress will be tracked through quarterly and annual reviews, mid-term strategic assessments, and a final program evaluation. Indicator dashboards will be developed to allow district teams, partners, and national leadership to visualize trends and act promptly on gaps.

Beyond collection and reporting, the framework prioritizes data use for decision-making. Key indicators will inform microplanning for MDA campaigns, prioritization of morbidity management services, resource allocation, and verification of elimination progress. Annual programme reviews will integrate NTD data into the broader health sector performance review process, ensuring that results are used to strengthen accountability, inform cross-sectoral interventions (e.g., WASH, One Health), and accelerate progress toward elimination targets.

Ultimately, this enhanced framework is designed to guide Rwanda's NTD program toward a more resilient, integrated, and sustainable model—driven by high-quality data, owned by local systems, and focused on measurable impact in line with the Health Sector Strategic Plan V (HSSP V) and UHC goals.

Table 22. Performance indicators for pillar 1

Strategic Objective	Performance Indicators	Target	Date
Strategic Objective SO1: Transition from vertical MDA to MDA embedded in PHC systems for STH and SCH	% of schools implementing routine MDA as part of school health services	100% of eligible schools	2030
	National guidelines and SOPs for routine MDAs finalized and disseminated	Approved by MoH	2027
	% of districts procuring and distributing deworming medicines annually through routine channels	100%	2030
SO2: Ensure 100% geographic coverage for MDA where indicated	% of endemic IUs achieving recommended MDA coverage (100% for STH and SCH, and Oncho)	100%	Annually through 2030
	% of targeted population reached during each MDA round	≥95%	Annually
	% of targeted population reached during each Oncho MDA round	≥85%	Annually
SO3: Scale up and strengthen Morbidity Management and Disability Prevention (MMDP) services	% of districts with functional MMDP services for LF, leprosy, and podoconiosis	100%	2030
	% of known morbidity cases receiving appropriate care	≥80% of registered cases	2028
SO4: Complete and maintain disease elimination dossiers	Number of validated disease elimination dossiers submitted to WHO	At least 3 (LF, Trachoma, Yaws)	2030
	% of submitted dossiers accepted by WHO	100% of submissions	2029
SO5: Enhance case detection and surveillance systems	% of health facilities reporting NTDs through the national HMIS	100%	2027
	% of suspected cases investigated within 48 hours	≥90%	2027
SO6: Establish rapid outbreak response for epidemic-prone NTDs	% of NTD outbreaks with response initiated within 72 hours	≥90%	2027
	% of districts with operational NTD outbreak response plans	100%	2027
SO7: Ensure sustainable vector control interventions	% of endemic districts implementing integrated vector control for relevant NTDs	100%	2030
	National integrated vector control strategy updated to include NTDs	Strategy finalized and operationalized	2027
SO8: Empowering districts and health facilities in endemic and non-endemic zones to organise and conduct leprosy case-finding campaigns	Proportion of child cases among total new cases detected.	<5%	2030
	New case-detection (number and rate per 100000)	0.15/100,000	2030
	Percentage of endemic health facilities that have conducted at least 8 ACF campaigns (2 per quarter) in their catchment areas in the reporting year	100%	2030
	Rate of newly diagnosed leprosy patients with visible deformities (G2D)	<5%	2030
	Proportion of MB cases among total new cases detected.	<30%	2030
	Proportion of female cases among total new cases detected.	>40%	2030
	Proportion of new PB patients assessed for disability status at least at the beginning and at end of treatment	>95%	2030
	Proportion of new MB patients assessed for disability status at least at the beginning and at end of treatment	>95%	2030
	MDT completion for new MB and PB cases.	>95%	2030
	Proportion of contacts screened.	>90%	2030

Strategic Objective	Performance Indicators	Target	Date
	Number of cases treated (new and retreatment) having developed leprosy reactions during treatment	< 2 cases	2030
	Update the leprosy treatment guidelines	Approved guidelines	2027

Table 23. Performance indicators for pillar 2

Strategic Objective	Performance Indicators	Target	Date
SO1: Mainstream integrated NTD services into PHC, school health, and WASH platforms	% of health centers delivering integrated NTD services (e.g., deworming, scabies, taeniasis, morbidity care)	100%	2030
	% of schools implementing routine deworming under the school health program	100% of target schools	2027
	Number of WASH programs/projects incorporating NTD risk-reduction components	At least 1 per high-burden district	2027
SO2: Operationalize One Health collaboration for zoonotic and vector-borne NTDs	National One Health action plan includes priority NTDs	Plan updated and endorsed	2027
	Number of joint outbreak simulation exercises or responses conducted with animal and human health sectors	≥1 per year	Annually
	% of priority zoonotic NTDs with joint surveillance and response protocols in place	100% (e.g., rabies, rHAT, cysticercosis/taeniasis)	2028
SO3: Integrate NTD indicators and reporting into national HMIS/DHIS2 systems	% of priority NTD indicators included in national HMIS/DHIS2	100%	2027
	% of districts reporting complete and timely NTD data through DHIS2	100%	2028
	Percentage of endemic health facilities that have had at least 2 supervisory visits from the central level in the reporting year	100%	2027
SO4: Strengthen joint community-based delivery platforms for NTD interventions	% of districts conducting joint CHW–WASH–SBC microplanning sessions for integrated NTD delivery	≥90% of districts	2027
	% of CHWs trained to deliver or support integrated NTD services	≥90% of CHWs	2028
	% of frontline health workers receiving integrated NTD training (including community delivery linkages)	≥90%	2028

Table 24. Performance indicators for pillar 3

Strategic Objective	Performance Indicators	Target	Date
SO1: Enhance institutional capacity of the NTD Program for coordination, planning, and multisector engagement	% of planned national NTD coordination meetings conducted annually	100%	Annually
	NTD Unit staffing level (as % of approved organogram)	≥90%	2028
	Multisector NTD coordination framework developed and operational	Framework in place and implemented	2027
SO2: Strengthen subnational human resource capacity for NTD planning, delivery, monitoring, and supervision	# of district-level NTD focal points trained and in place	100% of districts	2028
	% of health facilities with at least one NTD-trained staff member	100%	2028
	Annual national and district NTD training sessions conducted	≥1 per level per year	Annually
SO3: Institutionalize NTD accountability mechanisms at national and decentralized governance structures	% of districts with NTD indicators integrated into performance contracts	100%	2027
	NTD planning integrated into annual district health plans	All 30 districts	2027
SO4: Ensure quality NTD service delivery through	% of districts conducting at least two integrated NTD supervision visits per year	≥90%	Annually

integrated routine and supportive supervision and monitoring systems	National NTD supportive supervision tool finalized and rolled out	Tool adopted and used	2027
SO5: Strengthen the supply chain and logistics system for NTD medicines, diagnostics, and commodities	% of health facilities reporting no stock-out of NTD medicines/diagnostics in the last 3 months	≥90%	2028
	National NTD logistics and forecasting tool integrated into eLMIS and other electronic system	Tool updated and used routinely	2027
SO6: Strengthen NTD research capacity in collaboration with relevant programs and research institutions	National NTD research agenda developed and endorsed	Agenda approved	2026
	# of NTD operational or implementation research studies conducted	≥1 per year	Annually
	# of formal research collaborations with national or international institutions	≥2 active partnerships	2027

Table 25. Performance indicators for pillar 4

Strategic Objective	Performance Indicators	Target	Date
SO1: Mobilize domestic financial resources to cover at least 70% (in line with HSSP V) of the national NTD program budget by 2030	% of national NTD program budget financed from domestic sources	≥70%	2030
	Existence of a dedicated NTD budget line within the national health budget	Budget line established and funded	2026
	% of districts with an allocated NTD budget line in annual health plans	100% of districts	2028
	Annual increase in domestic financing for NTDs (year-on-year)	Sustained annual increase	Annually
SO2: Coordinate and align implementing partners around national NTD priorities and activity plans	% of partner-supported NTD activities aligned to the national NTD strategic plan and annual operational plans	100%	2027
	# of annual national NTD partner coordination meetings held	≥2 per year	Annually
	Existence of a national NTD partner coordination framework and joint results matrix	Framework adopted and in use	2027
SO3: Engage the private sector in NTD program planning, financing and delivery	# of formal public–private partnership (PPP) agreements supporting NTD interventions	≥3 active partnerships	2028
	% of annual NTD budget leveraged from private sector contributions (financial or in-kind)	Increasing year-on-year	Annually
	# of private sector entities participating in NTD planning, implementation, or service delivery	≥5 entities	2027
SO4: Ensure strengthened local NTD governance platforms at the district level	% of districts with functional multisectoral NTD coordination platforms	100% of districts	2027
	# of districts conducting at least one annual NTD coordination review meeting	100% of districts	Annually
	% of districts integrating NTD priorities into district development and health plans	100%	2026

5. Budgeting for Impact: Estimates and Justifications

5.1. Overview of the NTD program budget

The National Neglected Tropical Diseases (NTD) Strategic Plan for Rwanda (2026–2030) is underpinned by a comprehensive, realistic, and results-oriented budget aligned with national health priorities and World Health Organization (WHO) guidance. The budget has been designed to support effective implementation of the Strategy while serving as a practical management tool for annual planning, coordination, partner alignment, and resource mobilization.

The total estimated cost of implementing the Strategy over the five-year period is **RWF13,994,544,980**.

Cost estimates reflect Rwanda's epidemiological context, the progressive transition from disease-specific mass interventions to people-centered and integrated service delivery platforms, and the need to sustain elimination gains while preventing re-establishment of transmission. Budget priorities are fully aligned with the WHO NTD Roadmap 2021–2030, emphasizing country ownership, integration within routine health services, cross-sectoral action, and sustainable financing.

Following confirmation of ongoing onchocerciasis transmission, a standalone, fully costed National Onchocerciasis Elimination Plan has been developed to support accelerated intervention in affected areas. Given the timing and specificity of this response, the costs associated with onchocerciasis elimination are presented separately and are not fully integrated into the consolidated NTD budget at this stage. However, the onchocerciasis plan is strategically aligned with this NTD Strategic Plan in terms of governance, service delivery platforms, monitoring and evaluation, and use of national health information systems.

Costing was undertaken using an activity-based methodology consistent with the WHO Tool for Integrated Planning and Costing (TIPAC). Detailed assumptions, standardized unit costs, implementation frequencies, and annual projections are documented in the **NTD Costing Tool (Annex: RW-NTD Costing Template Master_V2 2026 Jan)**, which serves as the authoritative reference for all summary tables and figures presented in this section.

5.2. Costing methodology and budget structure

The NTD programme budget was developed through a structured, activity-based costing process aligned with WHO TIPAC guidance. Costs were derived from clearly defined implementation activities linked directly to strategic objectives under each pillar. Unit costs reflect national norms for trainings, supervision, logistics, and service delivery, while explicit assumptions regarding coverage, duration, and frequency were applied to ensure realism and implementation readiness.

Particular attention was given to unpacking cost drivers, integrating activities within existing health system and community platforms, and minimizing duplication across programmes. This approach enhances cost-effectiveness while strengthening alignment with national systems and partner investments. Annual cost projections were sequenced to reflect realistic scale-up, consolidation, and sustainability phases across the strategy period.

5.3. Budget distribution by strategic pillar

Budget allocations across the four strategic pillars reflect disease burden, implementation intensity, and the sequencing required to achieve, verify, and sustain elimination outcomes while strengthening system resilience.

5.3.1. *Accelerating Disease-Specific Interventions and Elimination*

RWF 9.29 billion (65% of total budget)

Pillar 1 represents the largest share of the programme budget, reflecting Rwanda's priority to consolidate elimination gains and complete the transition from mass drug administration to sustainable routine service delivery. Investments under this pillar support nationwide transition to routine deworming, maintenance of full geographic MDA coverage where required, and scale-up of morbidity management and disability prevention (MMDP) services. Significant resources are also directed toward enhanced surveillance and case detection, completion and maintenance of elimination dossiers for WHO verification and validation, rapid outbreak preparedness and response, and targeted vector control in residual transmission areas. The concentration of costs under this pillar reflects the intensity of investments required during elimination phases and is expected to decline progressively as elimination is sustained and integrated service delivery matures.

5.3.2. *Strengthening Integrated and Community-Based Service Delivery*

RWF 3.07 billion (21% of total budget)

Investments under Pillar 2 focus on embedding NTD prevention, diagnosis, and care within existing primary health care (PHC), WASH, and community-based delivery platforms. Budget allocations prioritize joint community-based delivery mechanisms, integration of NTD services and indicators into routine HMIS/DHIS2 reporting, operationalization of One Health collaboration, and incorporation of NTD diagnostics and training into existing health programmes. These investments operationalize the shift from vertical programming toward integrated, people-centered service delivery platforms that improve efficiency, expand reach to underserved populations, and enhance long-term sustainability.

5.3.3. *Enhancing Institutional Capacity, Supervision, and Systems*

RWF 1.08 billion (11% of total budget)

Pillar 3 strengthens the institutional and operational foundations required for effective, accountable implementation of the NTD programme. Key investments focus on enhancing the capacity of the national NTD & OPDs Unit, strengthening human resource capacity for planning, supervision, and monitoring, and institutionalizing supportive supervision systems across decentralized levels. Additional resources reinforce supply chain and logistics functions essential for uninterrupted service delivery and strengthen accountability mechanisms within district and facility structures. Although proportionally smaller, these investments are critical to implementation quality, system resilience, and evidence-based decision-making across all pillars.

5.3.4. *Financing Sustainability, Partner Alignment, and Multisectoral Coordination*

RWF 553 million (3% of total budget)

Pillar 4 supports catalytic investments aimed at strengthening financing sustainability and coordination across stakeholders. Budget allocations cover domestic resource mobilization initiatives, alignment of partners under a unified results framework, engagement of private sector actors, and institutionalization of multisectoral coordination platforms. These investments underpin national ownership, improve coherence of partner contributions, and create an enabling environment for sustaining NTD control and elimination beyond the life of the Strategy.

5.4. Summary budget by strategic pillar and main activities

The allocation of resources across strategic pillars is operationalized through a defined set of priority activities that translate strategic objectives into implementable investments. **Table 26** summarizes the NTD programme budget by strategic pillar and major activity area for the period up to 2030 and provides a consolidated view of investment priorities.

Table 26. Summary of NTD Program Budget by Strategic Pillar and Major Activities

Pillars	Main Activities	Estimated Budget
Pillar 1	Transition from MDA to routine deworming	7,115,020,000
	Ensure 100% geographic coverage for MDA	544,640,000
	Scale-up and strengthen MMDP services	843,405,000
	Complete and maintain elimination dossiers	127,600,000
	Enhance case detection and surveillance	489,780,000
	Establish rapid outbreak response	52,030,000
	Ensure sustainable vector control	117,550,000
Pillar 2	Mainstream NTD services into PHC & WASH platforms	810,540,000
	Operationalize One Health collaboration	363,300,000
	Integrate NTD indicators into HMIS/DHIS2	266,410,000
	Strengthen joint community-based delivery	1,424,320,000
	Integrate diagnostics & training into existing programs	202,670,000
Pillar 3	Enhance NTD Unit institutional capacity	490,199,980
	Strengthen HR capacity for NTD planning & supervision	180,300,000
	Enhance intersectoral collaboration for WASH & vector control	63,000,000
	Institutionalize NTD accountability in decentralized structures	66,260,000
	Establish supportive supervision & monitoring systems	138,820,000
	Strengthen NTD supply chain & logistics	145,600,000
Pillar 4	Mobilize domestic financial resources	177,500,000
	Align partners under unified results framework	119,020,000
	Engage private sector participation	100,360,000
	Institutionalize multisectoral coordination platforms	156,220,000
TOTAL		13,994,544,980

Figure 10 below summarizes the proportional distribution of the NTD programme budget across the four strategic pillars.

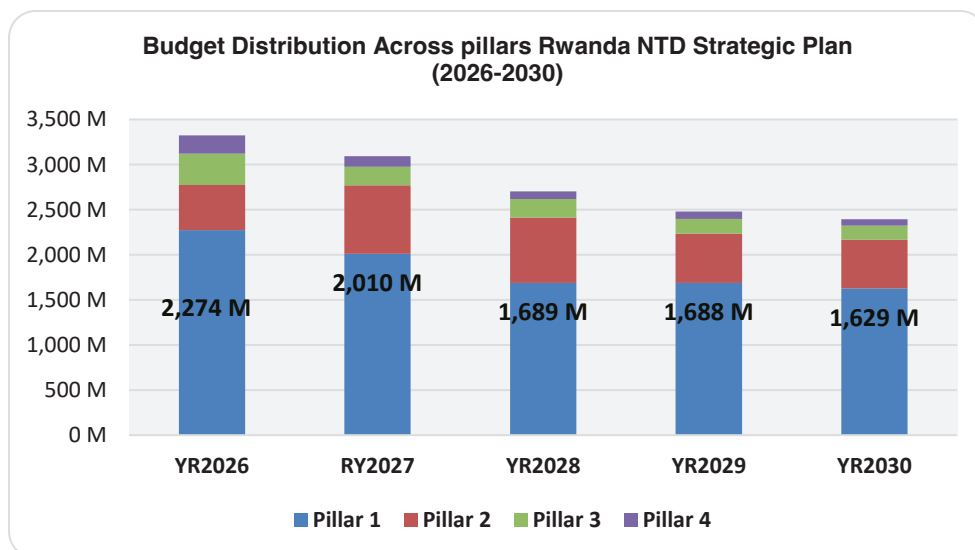


Figure 10. Distribution of the NTD Program Budget by Strategic Pillar

The above figure presents the proportional allocation of the total NTD programme budget across the four strategic pillars, highlighting prioritization of disease-specific elimination interventions (Pillar 1), complemented by investments in integrated service delivery platforms (Pillar 2), institutional capacity strengthening (Pillar 3), and domestic resource mobilization and multisectoral coordination (Pillar 4). Source: NTD Costing Tool – Summary Dashboard (Annex RW-NTD Costing Template Master_V2 2026 Jan).

5.5. Financing considerations and resource mobilization

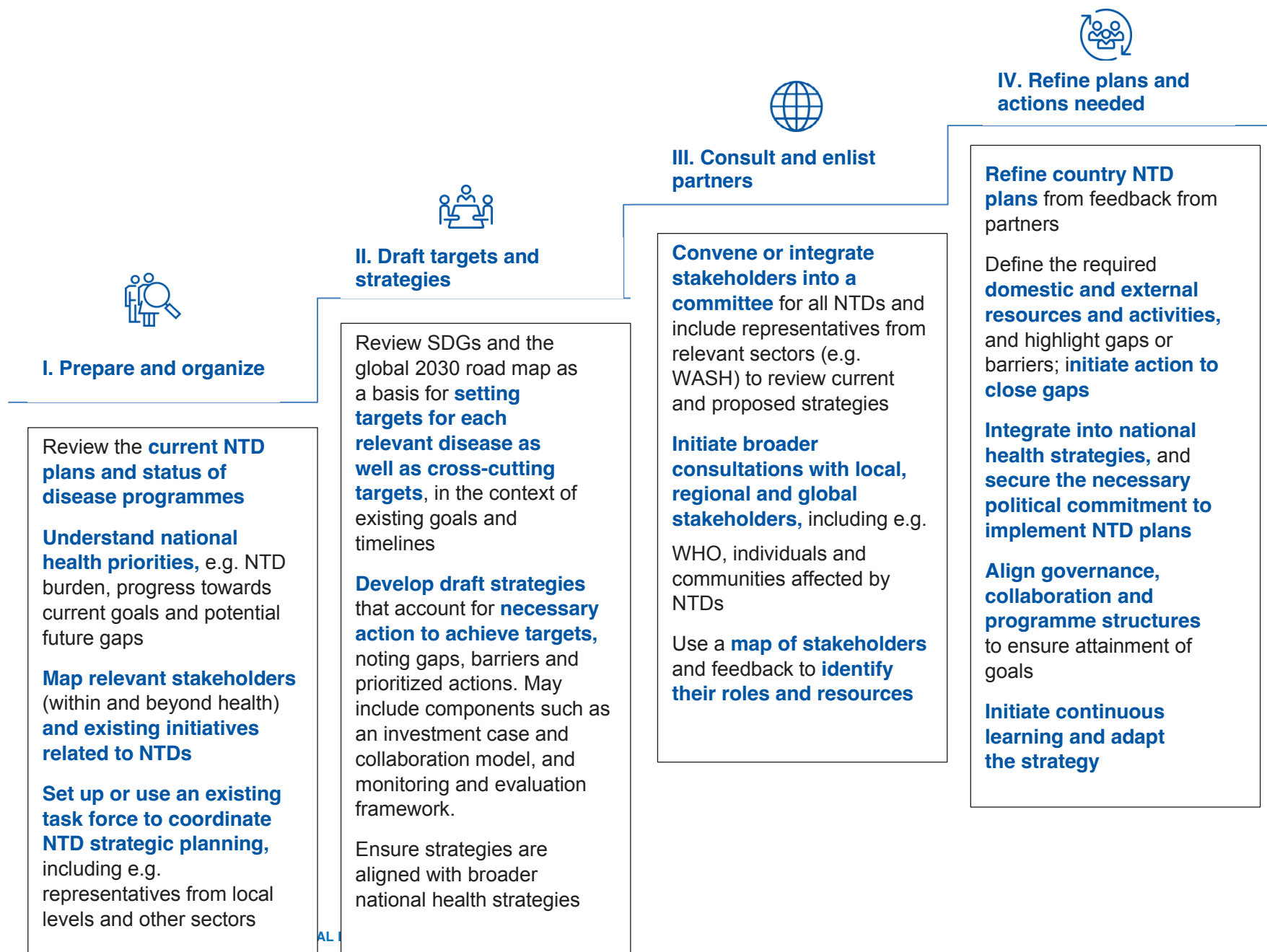
While Table 29 reflects the full resource requirements for effective implementation of the NTD Strategic Plan, realization of these investments will depend on a combination of domestic financing and external partner support. The Government of Rwanda is committed to progressively increasing domestic allocations for NTDs, particularly for integrated service delivery platforms, surveillance, and system strengthening. The budget therefore serves both as an implementation instrument and a resource mobilization framework, guiding partner alignment toward priority gaps in support of national targets and the WHO NTD Roadmap. Targeted resource mobilization for onchocerciasis elimination will be integrated within the broader NTD financing framework, ensuring alignment, complementarity, and efficient use of shared systems and platforms.

Overall, the budget demonstrates a balanced and cost-effective investment strategy that prioritizes high-impact elimination outcomes while strengthening system integration, institutional capacity, and financing sustainability to ensure long-term control and elimination of NTDs in Rwanda.

6. Annexes

- Steps in designing/reviewing a national NTD Master Plan
- Proposed road map targets, milestones and indicators
- Organisational chart of the MoH and the NTD National Programme

1. Annex 1: Steps in designing/reviewing a national NTD Master Plan



Annex 2: Proposed Road map targets, milestones and indicators

Goal Category & Disease	Indicator	Baseline (2025)	2026	2028	2030	Source / Frequency
DISEASE ERADICATION						
Yaws	Years with zero indigenous cases verified	No verified zero-case year	2 consecutive yrs of zero cases	Dossier submitted to WHO	WHO certification achieved	Surveillance reports; Annual
ELIMINATION (INTERRUPTION OF TRANSMISSION)						
Onchocerciasis	% of foci mapped and ready for intervention	Mapping incomplete	100% mapping completed	≥50% foci with ≥1 MDA round	All foci with ≥2 rounds & entomological evidence	Mapping reports, DHIS2
Leprosy	Incidence <1/100,000 in all districts	12 districts >1/100,000	50% districts <1/10,000	≥90%	100% (interruption)	HMIS
SCH/STH (Subnational)	% prevalence in high-burden districts	SCH: 8%, STH: 12%	<5%	<2%	<2% (sustained)	Impact Assessment, Sentinel surveys every 3 years
ELIMINATION AS A PUBLIC HEALTH PROBLEM						
LF	% of IUs with prevalence <1%	92%	≥95%	100%	100% + validation dossier submitted	TAS surveys
Trachoma	TT prevalence <0.2% in ≥15 y	5 endemic districts	Dossier submitted	WHO validation achieved	Maintain validation	Trachoma surveys
Rabies	Annual human rabies deaths per 1M	1.7	<1	<1	0	IDSR monthly
SCH (National)	Heavy-intensity prevalence	3.1%	<2%	<1%	<1% (verified x2 surveys)	National and Sentinel surveys
STH (National)	Heavy-intensity prevalence	5.5%	<2%	<2%	<2% (maintained)	National and Sentinel surveys
DISEASE CONTROL						
Snakebite Envenoming	% of district hospitals stocked with antivenom	28%	40%	80%	100%	RMS supply chain data
Mycetoma, Scabies, Tungiasis, Taeniasis, Cysticercosis	Case management protocol adoption	No standard protocols	Protocol finalized	Implementation in ≥50% districts	100% integration + HMIS reporting	HMIS / program records
Podoconiosis	HF delivering services (Integrated into routine services)	14	30%	70%	100%	HMIS / program records
Echinococcosis	# of districts with intensified control program	0	2	5	≥7	Veterinary One-Health data
CROSS-CUTTING INDICATORS						

Integrated Service Delivery	% of health centres delivering integrated NTD services	68%	80%	95%	100%	DHIS2; Annual
School-Based Deworming	% of schools conducting deworming	82%	90%	90%	90% (sustained)	MoE/School health data
Multisectoral Collaboration	% of districts with joint NTD-WASH-Education action plans	45%	70%	90%	100%	District JADF records
Domestic Financing	% of NTD budget financed domestically	42%	55%	65%	≥70%	MoH/MINECO FIN
UHC Coverage	% of districts with CBHI covering NTD morbidity	20%	40%	70%	≥80%	CBHI data

Annex 3: Organizational chart of the MoH and the NTD National Programme

