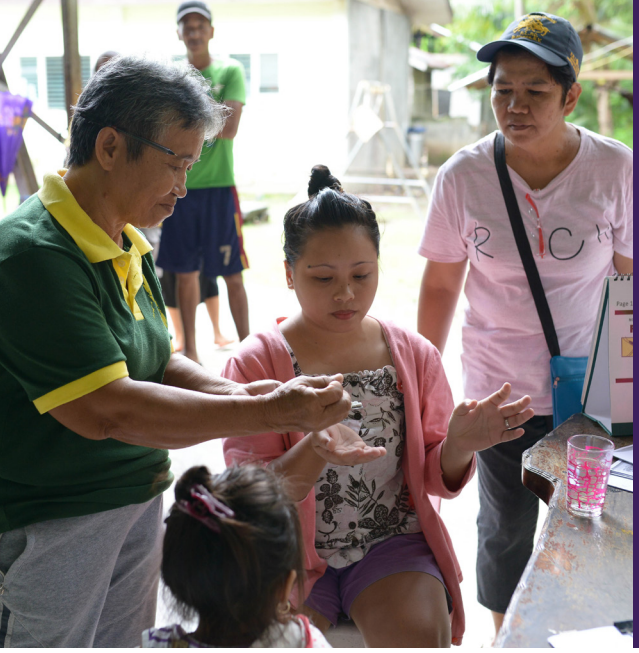

ACT TO END NTDS | EAST POLICY BRIEF SERIES

Mobilizing Domestic Resources for Neglected Tropical Diseases:

Highlights from Colombia, Guatemala, and the Philippines

Worldwide, significant progress has been achieved in addressing neglected tropical diseases (NTDs). NTDs are considered one of the best buys in public health due to the proven, low cost, and effective interventions available. However, governments face multiple challenges meeting the health needs of their populations, often managing limited domestic resources to address many competing priorities. To date, health services and interventions for NTDs have been left out of many national and subnational policy, planning, governance, and finance processes.

As they approach their NTD goals, governments must consider how best to sustain these gains and mobilize to efficiently utilize financing from domestic sources to ensure adequate coverage of NTD services. According to the WHO NTD Road Map 2030 (World Health Organization, 2021a) and the WHO NTD Sustainability Framework (WHO, 2021b), NTDs disproportionately affect the most disadvantaged and hard to reach populations and thus are integral to the achievement of universal health coverage (UHC). NTD interventions must be part of national systems and government-led efforts to optimize available health resources to address priority health needs as well as meet commitments toward achieving NTD goals; thus, domestic financing is critical to ensuring the sustainability of NTD services.

To identify lessons learned from countries that have achieved key elimination milestones and mobilized domestic resources in their NTD response, we conducted case studies in Colombia, Guatemala, and the Philippines, looking at focus NTDs. This synthesis document highlights common enabling factors in these three countries that contributed to resource allocation for NTDs at national and subnational levels. These lessons may be useful to NTD stakeholders in other countries who face similar challenges and opportunities.

Focus NTDs for this brief:

- Chagas Disease
- Leishmaniasis
- Lymphatic Filariasis
- Onchocerciasis
- Schistosomiasis
- Soil-transmitted Helminth Infections
- Trachoma

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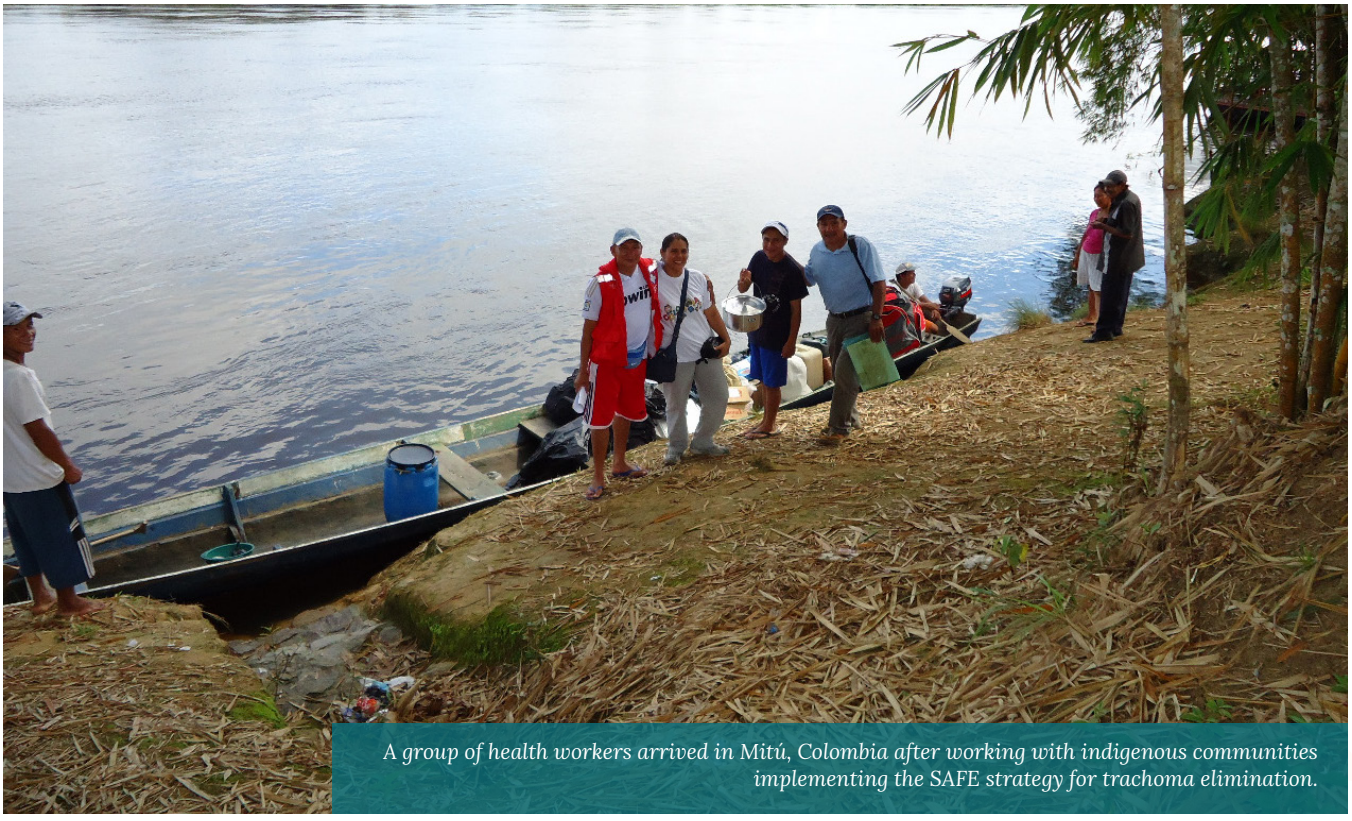
KEY MESSAGES

- In Colombia, Guatemala, and the Philippines, NTD programming is recognized as a national priority in relevant health policy documents and strategies that set priorities during the health sector budget allocation process.
- Domestic funding for health programs has benefited when the programs are integrated with broader health planning and budgeting processes and systems are in place to track budget allocations and expenditures as well as link these to results.
- Generation and use of NTD program and financial data helped inform prioritization and decision making for use of limited health resources amidst competing priorities and health system challenges.
- Health ministries in the three countries have effectively coordinated NTD financial and programmatic efforts, while also incorporating and managing external donor and multi-stakeholder contributions, to ensure progress toward meeting international and national NTD commitments.
- WHO has provided external accountability and advocacy structures for greater prioritization of NTD interventions that have influenced governments and policy development.



A group of health workers arrived in Mitú, Colombia after working with indigenous communities implementing the SAFE strategy for trachoma elimination.

NTDS IN COLOMBIA, GUATEMALA, AND THE PHILIPPINES

The WHO NTD Road Map 2030 calls for the prioritization of 20 NTDs[1] and disease groups. From this list, Colombia is endemic for 15, the Philippines is endemic for 10, and Guatemala is endemic for 11 NTDs. NTDs of public health importance and key successes to date in the three countries are shown in ***Figure 1***.

FIGURE 1. NTDS OF PUBLIC HEALTH IMPORTANCE AND KEY SUCCESSES IN CASE STUDY COUNTRIES

Colombia

NTDs of Public Health Importance

*Chagas disease**
Cysticercosis
*Trachoma**
Leishmaniasis
Leprosy
*Onchocerciasis**
Scabies
*Soil-transmitted helminthiasis (STH)**
Yaws

Key NTD Successes

In 2013, Colombia received official WHO verification of **onchocerciasis elimination**.

As of 2020, PAHO has verified the interruption of vector transmission of **Chagas disease** in 67 municipalities and certified the interruption in 66 municipalities.

Guatemala

NTDs of Public Health Importance

*Chagas disease**
*Leishmaniasis**
Leprosy
*Onchocerciasis**
*Soil-transmitted helminthiasis (STH)**
*Trachoma**

Key NTD Successes

In 2008, Guatemala received WHO certification for the interruption of **Chagas disease** transmission due to the main domestic vector, Rhodinus prolixus.

In 2016, WHO verified Guatemala's elimination of **onchocerciasis** transmission.

In 2019, the country eliminated the main domestic vector for **Chagas disease** as a public health problem.

Philippines

NTDs of Public Health Importance

Food-borne trematodiases
Leprosy
*Lymphatic filariasis (LF)**
Rabies
*Schistosomiasis (SCH)**
*Soil-transmitted helminthiasis (STH)**

Key NTD Successes

Mass drug administration for **lymphatic filariasis** stopped in 43 of 46 endemic provinces.

*Focus NTDs for the country analyses.

HEALTH GOVERNANCE AND FINANCING OF NTD ACTIVITIES

POLICY FORMULATION AND STRATEGIC DIRECTION

In Colombia, Guatemala, and the Philippines, policy formulation and strategic direction of the health system and national health programs, including NTDs, are the responsibility of the health ministries. Each country's ministry has developed an NTD master plan as a policy instrument to increase NTDs' visibility, coordinate interventions at the national and subnational level and across sectors, and commit

1 NTDs prioritized by WHO for control, elimination, and eradication are Buruli ulcer, Chagas disease, dengue and chikungunya, dracunculiasis, echinococcosis, foodborne trematodiases, human African trypanosomiasis, leishmaniasis, leprosy, lymphatic filariasis, mycetoma, chromoblastomycosis and other deep mycoses, onchocerciasis, rabies, scabies and other ectoparasitoses, schistosomiasis, soil-transmitted helminthiases, snakebite envenoming, taeniasis and cysticercosis, trachoma, and yaws.

specific domestic resources to accelerate progress toward NTD goals.

In **Guatemala**, NTD activities are directly implemented, monitored, and coordinated by the Ministry of Public Health and Social Assistance (*Ministerio de Salud Pública y Asistencia Social*, MSPAS); whereas in **Colombia** and the **Philippines**, subnational governments share the responsibility for planning and implementing NTD activities with the health ministries. In the three countries, WHO regional and national offices have also played a crucial role in providing technical assistance, strategic planning guidance, and advocacy. Technical groups responsible for NTD programming within their health ministries coordinate activities with donors, the private sector, and other public institutions and ministries, ensuring their alignment with national policies and priorities.

To advance strategic objectives and guide public health investments at national and subnational levels, the health ministries have developed national health plans that serve as a medium-term roadmap toward achieving strategic health goals. For instance, in **Colombia**, the Ministry of Health and Social Protection (*Ministerio de Salud y de la Protección Social*; *MinSalud*) developed the National Health Plan 2012–2021 (MinSalud, 2013) that includes clear objectives, targets, and strategies to achieve health goals, including for selected NTDs in line with international commitments signed by the country. In the **Philippines**, the Department of Health (DOH) set national health priorities in the National Objectives for Health 2017–2022 (DOH, 2018), a national health plan that includes clear elimination targets for LF and SCH. The plan also establishes the inclusion of elimination strategies in essential health services. Strategic plans for public health interventions and NTDs at subnational levels are thus anchored on national health plans and targets in both countries.

MONITORING AND TECHNICAL ASSISTANCE

Health ministries have a key role in monitoring NTD activity implementation, developing guidance and standards, and providing technical assistance to subnational governments. In **Colombia**, MinSalud monitors the progress of mass drug administration (MDA) and other population-based activities, provides technical and administrative assistance to subnational health secretariats, and oversees implementation according to the national guidance and plans. In the **Philippines**, the DOH (national and regional offices) provides coordination, technical assistance, capacity building, consultancy and advisory services to the local government units (LGUs). In **Guatemala**, the MSPAS carries out implementation, supervision, and monitoring activities through the Health Areas Directorates (*Direcciones de Áreas de Salud*, DAS). The DAS are subnational health authorities that oversee population-based interventions and clinical care provided by public health centers and primary health posts managed and operated by health districts.

FINANCING

In the three countries, funding for NTDs has been coordinated and mobilized across different funding streams and at different levels of government for both population-based and clinical services. **Table 1** summarizes funding responsibilities for the different components of NTD programming.

In **Colombia**, population-based interventions for NTDs are financed by national and subnational governments (departments districts, and municipalities), while clinical care is primarily funded through the compulsory health insurance system. Funding for population-based interventions comes from the National Public Health Budget, allocated monthly to subnational governments by the Ministry of Finance and Public Credit (*Ministerio de Hacienda y Crédito Público*; *MinHacienda*). For NTDs managed

under the Vector-Borne and Zoonotic Diseases Program, MinSalud provides endemic departments and municipalities with additional earmarked funds for staff and indirect costs based on epidemiologic and social variables. Funding transferred by MinSalud must be matched by subnational levels' counterpart funds and executed according to strict MinSalud guidelines.

In **Guatemala**, the MSPAS finances population-based interventions as part of the government's health budget and assigns annual budget allocations to each NTD subprogram based on historical budgets. Similarly, clinical care for NTDs (including diagnosis, morbidity management, disability prevention, and rehabilitation) is funded through health care facilities with resources allocated to the DAS and operated by the health districts. Therefore, funding for population-based interventions and clinical care is annually allocated by the MSPAS to the DAS including for NTDs, and similarly by the DAS to health districts that manage and operate public health centers and primary health posts.

Much of the **Philippines'** NTD efforts are financed by the government, with different sources of funding for population-based interventions and clinical care. In general, population-based interventions (e.g., MDA, surveillance, active case finding, and educational activities) are covered by the DOH and LGUs, while individual-based clinical case interventions are covered by the Philippine Health Insurance Corporation (PhilHealth), which reimburses both government-owned and private service providers and LGUs. Each of these bodies has distinct roles, and they work together to cover all NTD services.

TABLE 1. FINANCING RESPONSIBILITIES FOR KEY NTD FUNCTIONS IN COLOMBIA, GUATEMALA, AND THE PHILIPPINES

COMPONENT	COLOMBIA	GUATEMALA	PHILIPPINES
Procurement of Drugs and Diagnostics	PAHO provides technical support and guidance in accessing global drug donations for STH, managed through WHO. Drugs from trachoma are procured by countries through the International Trachoma Initiative. Additionally, PAHO supports both counties to strengthen the diagnosis of congenital Chagas disease and procurement of drugs for the treatment of leishmaniasis and Chagas disease.		DOH procures most drugs for LF MDA. Philippines also receives donated test kits and drugs for LF and leprosy from GlaxoSmithKline and Novartis that are facilitated by WHO. LGUs fund drugs for deworming of children and pregnant women.
Mass Drug Administration	Population-based interventions, including MDA, are bundled into a package of community-based interventions through which subnational levels fund and execute most of the activities in their territorial health plan.	The MSPAS finances population-based interventions (surveillance, MDA, vector control) as part of the government's health budget.	DOH funds population-based activities for LF, SCH, and STH. LGUs and the Department of Education pay for the allowances of health personnel who oversee MDA activities.

COMPONENT	COLOMBIA	GUATEMALA	PHILIPPINES
Clinical Care	Clinical care for all NTDs is funded through the compulsory health insurance system. (Most highly specialized surgeries, such as trichiasis surgery for trachoma, are not routine services and are instead conducted by trained specialists financially supported by MinSalud and PAHO.)	Clinical care is funded through health care facilities operated by the MSPAS. Additional efforts are being made to mainstream NTD efforts into national primary health care activities funded by the MSPAS.	Clinical care is funded by LGUs and through PhilHealth. Local health budgets fund individual NTD clinical case outpatient services, and social mobilization costs (e.g., per diem and transport of local teams, food). Similarly, PhilHealth pays for inpatient care for LF, SCH, and STH clinical cases, including hydrocelectomy.
Integrated Vector Control/ Management	Funding for integrated vector control/ management comes from the national health sector budget allocated monthly to subnational governments. Dengue, leishmaniasis, and Chagas disease programs receive additional earmarked funds for staff and indirect costs from MinSalud.	The MSPAS finances population-based interventions (surveillance, MDA, vector control) as part of the government's health budget.	The DOH allots money for vector control which is transferred to DOH hospitals. Regions and municipalities also fund population-based interventions such as integrated vector control efforts.
Surveillance	Surveillance activities are funded directly by subnational governments. The National Health Institute provides guidance and monitors the epidemiological situation of key diseases and public health events.	The MSPAS finances population-based interventions (surveillance, MDA, vector control) as part of the government's health budget.	The DOH allocates grants to LGUs to fund surveillance activities, with diagnostics provided by the DOH or through donation programs. Implementation of those activities is led by the LGUs, with the health workforce supported through LGU funds.

COMPLEMENTARY FUNDING FROM DONORS AND COOPERATION AGENCIES

Colombia, Guatemala, and the Philippines have shown strong commitment to their NTD goals, including through the financing of NTD activities over the past decades. Domestic funding has been complemented with technical and financial support from cooperation agencies, donors, and international public health organizations. In particular, donor support has been crucial to initiate NTD programs and stimulate domestic funding and commitment for NTDs. For instance, funding from the Onchocerciasis

Elimination Program for the Americas (OEPA)[2] in Colombia and Guatemala was matched by government contributions throughout OEPA's life cycle. This technical and financial cooperation agreement made it possible for both countries to eliminate transmission in 2013 and 2016, respectively.

In Colombia, Guatemala, and the Philippines, all projects funded by external aid have been approved bilaterally between the ministries and donors, with financial and technical needs co-developed by technical teams from both parties. Government coordination of NTD financial and programmatic efforts has facilitated NTD programs to strategically manage and guide donor contributions to cover specific needs and complement domestic funding.

ENABLING FACTORS INFLUENCING THE ALLOCATION OF DOMESTIC RESOURCES FOR NTDS IN COLOMBIA, GUATEMALA, AND THE PHILIPPINES

For Colombia, Guatemala, and the Philippines, we examined the country experiences around government-led coordination structures for NTD programming and donor support, financing arrangements for NTDs and level of integration with broader health sector planning and budgeting structures, and the inclusion of NTD goals in key health strategies and policies. Here we summarize the key enabling factors that have contributed to enhancing domestic financing for NTD programming in the three countries over the past two decades.

PRIORITY OF NTDS IN NATIONAL POLICY DOCUMENTS AND STRATEGIES

In the three countries, NTD programs are recognized as a national priority in relevant health policy documents and strategies that set priorities during the health sector budget allocation process. For instance, in **Colombia**, NTD targets and goals were included in the Colombia National Health Plan 2012–2021 (MinSalud, 2013). This increased their visibility in public health resource allocation at national and subnational levels and guided the creation of subnational health plans. Given that the National Health Plan defines public health investment lines for the health sector, MinSalud and local health authorities establish their annual budgets following the strategies and programs prioritized in the national plan and, consequently, in the territorial health plans, including NTDs.

In **Guatemala**, the NTD master plan—the 2013–2015 *Strategic Plan for the Prevention, Care, Control, and Elimination of Neglected Infectious Diseases* (Government of Guatemala, 2012a)—was aligned with the multisectoral 2012 Zero Hunger Plan (Government of Guatemala, 2012b), aimed at improving vulnerable populations' health and nutritional status. Through this programmatic and financing alignment, NTD programs received $11 million for intersectoral interventions for Water, Sanitation and Hygiene (WASH), agriculture, and health, including a healthy schools initiative implemented by the Ministry of Education that included deworming campaigns for children aged 2–4 years.

In the **Philippines**, NTD targets are embedded in both national and local health objectives, which promotes budget prioritization; they are incorporated into the National Objectives for Health (DOH, 2018).

2 OEPA is a regional initiative created in 1993 and managed by The Carter Center with financial support from Merck & Co. Inc., the U.S. Centers for Disease Control and Prevention (CDC), and USAID, as well as a group of international donors. See the Carter Center website, https://www.cartercenter.org/health/river_blindness/oepa.html, for more information.

The resource requirements of the individual NTD strategic plans are incorporated in the budget proposals of respective program units (DOH, LGUs). Political support also stimulates collaboration with other government agencies (e.g., the Department of Education), both at the national and local levels. Program managers for LF, SCH, STH and their technical groups have been the main champions, who have effectively advocated for increased funds for NTDs at the national and subnational levels.

INTEGRATION OF NTDS INTO HEALTH SECTOR PLANNING AND BUDGETING PROCESSES

Domestic funding for health programs benefits when programs are integrated with broader health planning and budgeting processes and when systems are in place to track budget allocations and expenditures, as well as link these to results. In the three countries, health ministries were able to situate NTDs within the broader political narrative and reforms that were being undertaken to strengthen the overall health system, including those devoted to the advancement of UHC and its objectives for ensuring equitable access and financial protection.

For instance, in **Colombia**, the integration of NTDs with national funding streams for UHC has mobilized additional resources. NTD diagnosis, morbidity management, disability prevention, and rehabilitation are being progressively incorporated in the national health insurance plan. This inclusion of NTD health services has enabled subnational governments to focus the public health budget on funding NTD population-based interventions. Moreover, the 2016 declaration of the right to health as a constitutional right secured additional long-term funding for the health sector, especially for public health interventions and health care services in rural and poor communities most directly affected by NTDs. Similarly, population-based interventions for NTDs are bundled into a package of community-based interventions called the Collective Intervention Plan, through which subnational governments execute most of the activities established in their four-year territorial health plan.

In 2012, **Guatemala** introduced the results-based budgeting approach to increase accountability in the health sector and better link planning, budgeting, and results. Although the country had been successful in including NTD efforts in key policy and planning documents, NTD activities were not initially prioritized for implementation of the results-based budgeting. Consequently, the NTD Strategic Plan's results and targets were not included in the new budgeting process, leading to limited monitoring and poor tracking of its financial performance. However, under the first phase of the results-based budgeting implementation (2012–2015), specific targets and results from the Zero Hunger Plan and the wider chronic malnutrition reduction plan were included in the results-based budget process, securing additional funding for deworming campaigns for children and intersectoral interventions, and facilitating wide-ranging political and popular support.

Between 2019 and 2020, two new NTD-related indicators were created by the MSPAS to monitor progress toward the Sustainable Development Goals (SDGs), in particular target 3.3. These indicators were also included by the Ministry in the results-based budgeting system and the government's management information system (called *Sistema Informático de Gestión*, or SIGES) as new budget lines, allowing them to track NTD budget execution, monitor the number of people benefiting from NTD interventions, and define annual targets. The alignment of NTDs with the SDG goals has become a key driver to enable programs to maintain their annual budget allocation, even though other health and disease programs are also pursuing sustainability planning—all competing for resources and prioritization. Thus, the need

to monitor progress toward the SDGs created an opportunity for NTDs to be integrated into the new results-based budgeting process, increasing their visibility in the discussion of national health resource allocation.

In the **Philippines**, as progress is made toward UHC, all individual-based services are scheduled to be incorporated into an outpatient/primary care package paid by PhilHealth by 2021. Currently, NTDs are embedded in the *Guidelines on the Classification of Individual-based and Population-based Primary Care Service Packages* (Admin. Order 2020-0040), which defines the comprehensive primary care service packages as either individual-based or population-based health services. This order guides DOH, LGU, and PhilHealth on financing and contracting services with primary care facilities. Consequently, the progressive inclusion of NTD-related services into clinical care services covered by PhilHealth is expected to reduce household out-of-pocket expenditure in the coming years.

EVIDENCE-BASED ADVOCACY AND SUSTAINED TECHNICAL SUPPORT TO SUBNATIONAL GOVERNMENTS

Generation and use of NTD program and financial data helped inform prioritization and decision making for use of limited health resources amidst competing priorities and health system challenges. NTD program staff were able to utilize data to identify needs and engage within health ministries and with local governments to understand how best to finance those needs (whether bundled in service packages paid through integrated financing pools or through earmarked funds or special initiatives for NTDs to reach "last mile" or otherwise underserved communities). In the three countries, the generation and use of data to drive decision making have been crucial to secure funding for NTDs.

In the **Philippines**, gathering clear evidence of epidemiological trends was used to create compelling arguments to increase funding and prioritize NTDs in the national budget. For example, the LF prevalence rate was used to lobby for the signing of Executive Order 369 s. 2004, which established the national program to eliminate LF. This Presidential directive also opened the door for collaboration with relevant government agencies, and ensured that LF elimination is prioritized in the DOH budget.

In **Colombia**, MinSalud created the Chagas Research Network in 2013, a learning platform through which local universities, research groups, public institutions, and the private sector collaborate to generate evidence on epidemiological trends, social and environmental determinants, and barriers to health care access. MinSalud has used evidence generated by the network to inform new policies and guidelines and for advocacy with local health secretariats. Sustained advocacy and technical support to subnational governments have ensured the prioritization of NTDs within territorial health plans and budgets. Budget allocation decisions are made by governors and mayors every 4 years when they are elected and formulate their development and territorial health plans. Therefore, major NTD advocacy efforts for greater prioritization and resource allocation occur at the subnational levels. Additionally, MinSalud provides local health secretariats with continuous technical support for the planning, budgeting, and implementation of NTD activities. For instance, each year MinSalud, with PAHO's support, organizes technical meetings with mayors and supports national workshops with local health secretariats to position NTD activities.

COORDINATION OF NTD FINANCING AND DONOR SUPPORT

Health ministries in the three countries have effectively coordinated NTD financial and programmatic efforts at national and subnational levels of government, while also managing external donor and multi-stakeholder contributions, to ensure progress toward international and national NTD commitments.

For example, in **Guatemala** and the **Philippines**, donor-funded projects and activities have been developed between the health ministries and donors, with financial needs identified by both parties. This coordination has allowed governments to make annual health financing decisions, allocate funding to meet specific resource needs, and ensure donor contributions complement the domestic NTD budget. Moreover, this coordination ensures partners' investment aligns with national policies and guidelines.

Likewise, in **Colombia**, MinSalud has strategically coordinated external support and complemented domestic resources with donor contributions to ensure alignment of NTD interventions with national plans. Cooperation agreements were particularly relevant in the early stages of the program's development to generate epidemiological baseline data, develop intervention protocols, and create capacity in endemic areas to diagnose and provide care for NTDs. Indeed, donor technical and financial support catalyzed and was coupled with MinSalud's earmarked allocation. Once NTD programming is established, the MinSalud devolves coordination and financing functions to the subnational governments. This financing arrangement has been successfully implemented for onchocerciasis, trachoma, and Chagas disease.

WHO REGIONAL OFFICE ACCOUNTABILITY AND ADVOCACY STRUCTURES

WHO has provided external accountability and advocacy structures for prioritization of NTD interventions that have influenced governments and policy. Additionally, In the three countries, WHO regional offices have played a crucial role in building programs' technical capacity and developing regional NTD initiatives that have increased domestic financial commitments.

For instance, PAHO has led the creation of several NTD control initiatives in the **Americas Region** to prioritize NTDs as part of their national health strategies, including the regional Plan of Action for the Elimination of Neglected Infectious Diseases and Post-elimination Actions 2016–2022 (PAHO, 2016) that were signed by the 35 Member States including **Colombia** and **Guatemala**, the Andean Countries' Initiative to Control Vectoral and Transfusional Transmission of Chagas Disease (IPA) (*Iniciativa de los Países Andinos*), and similar initiatives for the control of Chagas disease in the Amazon countries, countries of Central America, and the southern cone countries. By following PAHO's leadership, the countries' political and financial commitments to NTDs have been fueled by the government's interest in maintaining its own leadership position in NTDs and meeting regional targets.

In the Philippines, the WHO Western Pacific Regional office (WPRO) has provided technical assistance to the DOH through setting standards for elimination, supporting the development of strategic masterplans for individual NTDs, augmenting program management staff, facilitating the donation of commodities for MDA from pharmaceutical companies (e.g., GlaxoSmithKline, Novartis), and most recently, developing the NTD management information system. In 2012, WPRO launched the *Regional action plan for neglected tropical diseases in the Western Pacific Region (2012-2016) (WPRO, 2013).*

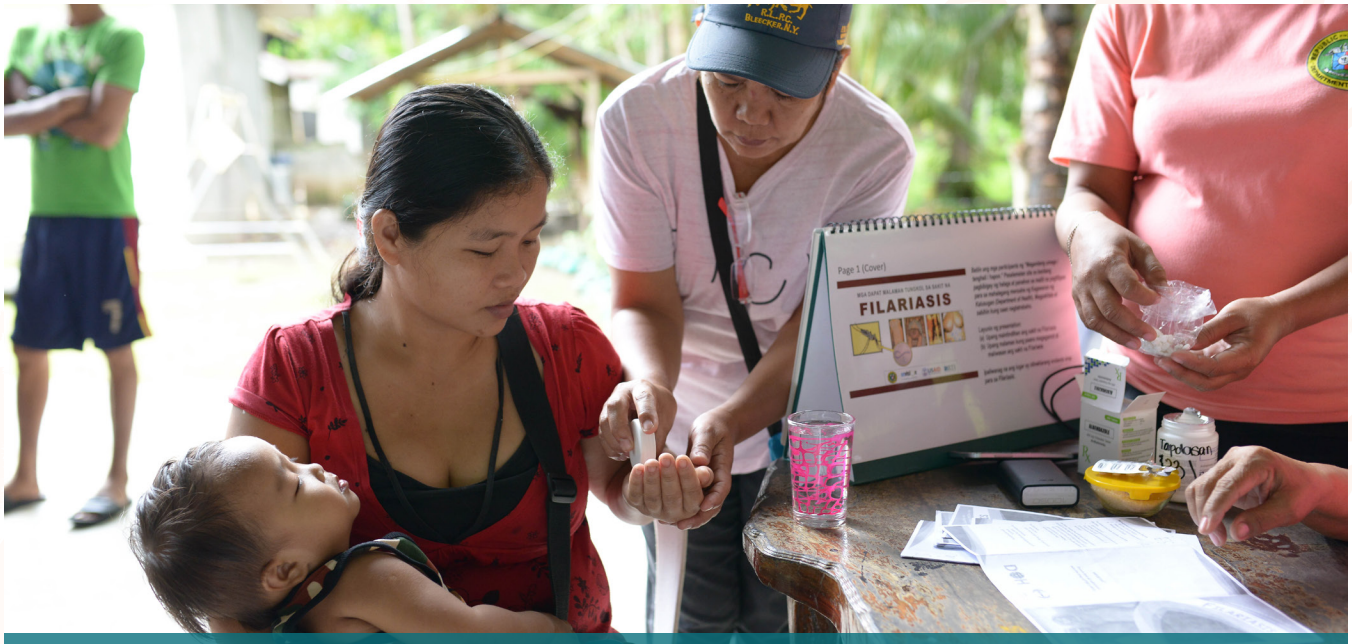
This document created a regional accountability structure for NTDs and has been important in maintaining and increasing political will to achieve regional goals and targets.

CONCLUSION

The case study countries have achieved notable success in financing their NTD response with financing from domestic sources. The countries utilized a mix of financing instruments at national and decentralized levels to fund both population-based interventions and clinical care, including pooled UHC-oriented financing mechanisms as well as domestic funds earmarked for NTDs and, in some instances, included requirements for matching funds and/or performance incentives. External donors also provided supplemental resources in the form of technical and advocacy support, strategic guidance (and donation of test kits and drugs), and financial support that helped to elevate the response locally.

Several enabling factors have increased domestic financial ownership of NTD programming at both national and subnational levels in Colombia, Guatemala, and the Philippines. NTD interventions are more sustainably financed when (1) NTDs are prioritized in national health plans and strategies at all levels of the government, and as an essential service under UHC; (2) NTDs are integrated into the health sector planning and budgeting processes; (3) ministries implement evidence-based advocacy plans and sustained technical support to subnational governments; (4) countries effectively coordinate and manage NTD financial and programmatic efforts from different sources; and (5) governments are held accountable to meet their commitments to national and regional NTD targets.

Governments of NTD endemic countries could benefit from these examples as they approach NTD milestones and reconfigure national funding streams to advance UHC goals. National reforms that increase the fiscal space for health present a good opportunity to expand clinical care for NTDs and



Treatments for lymphatic filariasis are provided to parents and children at a local school in the Davao region of the Philippines.

secure funding for population-based interventions that have relied on funding from donors in many countries. Additionally, effective use of epidemiological and financial data can help inform advocacy and planning for greater prioritization of NTDs, influence resource mobilization needs, and achieve sustainable progress.

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