UK Coalition against NTDs: Annual report 2012
Report for the All-Party Parliamentary Group on Malaria and Neglected Tropical Diseases

Chairman: Jeremy Lefroy MP

Vice Chairmen: Lord Rea, Eleanor Laing MP, Kevin Barron MP, Pauline Latham OBE MP, Baroness Hayman GBE, PC

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Introduction

NTD control and elimination contributes to the UK government priorities in international development and the post 2015 development agenda

2012 has seen an unprecedented increase commitment from the UK government and other donors to support NTD control and elimination

There have been significant changes in the delivery paradigms with convergence of efforts essential as programmes move from control to elimination

Operational research successes

Fact sheets on common NTDs

Neglected Tropical Diseases Debate

Global Fund: AIDS, Tuberculosis and Malaria
This year has seen good progress in the fight against neglected tropical diseases. A highlight was the London Declaration on Neglected Tropical Diseases and the UK Government’s commitment to provide funding of £240 million over 4 years. I welcome too the pledge of the US Government to spend $450 million over five years on NTDs.

We owe a great deal too to the commitment of the pharmaceutical companies who not only donate hundreds of millions of treatments for NTDs every year but have also pledged to continue doing so, in some cases until a disease is under control.

The funds pledged by the UK, the USA and other countries will help endemic countries to pay for the delivery of these donated drugs. They will also fund the work of research and development of new treatments for the other NTDs.

At this point I wish to pay tribute to Rt. Hon Andrew Mitchell, the previous Secretary of State at DfID and to Stephen O’Brien MP, the previous Parliamentary Under Secretary at DfID for all the help and encouragement they have shown to the All-Party Group, it is greatly appreciated.

The UK is a world leader in the work to tackle NTDs. The Liverpool and London Schools of Tropical Medicine and Imperial College London all have extensive programmes into several of the diseases; and British pharmaceutical companies are at the forefront of drug development. Vaccine development programmes are also important.

It is essential that the work is a partnership with the countries in which NTDs are endemic. While campaigns supported by donors to treat individual NTDs can bring substantial short-term benefits, they will be more effective if they are delivered by local health workers as part of an established public health system or teachers in school health programmes.

That depends on the countries themselves increasing the share of the national budget spent on health. Many have signed the Abuja Declaration which commits them to spending 15 per cent of their budget on health; however most are well short of this figure. They need to meet it as soon as possible.

Great progress has been made over the past decade in tackling NTDs, with almost one billion treatments now being delivered every year. If this continues, we could see the world largely free of many of them by 2020. Not only would it be a major advance in tackling extreme poverty and its effects, it would also be powerful evidence of the value of well-targeted aid.

I would like to thank all those who have made the work of the APPG possible, especially the indefatigable and ever cheerful Susan Dykes, Owen Meredith and Hetty Bailey. I am also most grateful to my parliamentary colleagues who support its work and in particular Pauline Latham MP, Baroness Hayman GBE, PC and Lord Rea.
THE LONDON DECLARATION ON NEGLECTED TROPICAL DISEASES

For decades, partners including pharmaceutical companies, donors, endemic countries and non-government organisations have contributed technical knowledge, drugs, research, funding and other resources to treat and prevent Neglected Tropical Diseases (NTDs) among the world’s poorest populations. Great progress has been made, and we are committed to build on these efforts.

Inspired by the World Health Organization’s 2020 Roadmap on NTDs, we believe there is a tremendous opportunity to control or eliminate at least 10 of these devastating diseases by the end of the decade. But no one company, organization or government can do it alone. With the right commitment, coordination and collaboration, the public and private sectors will work together to enable the more than a billion people suffering from NTDs to lead healthier and more productive lives – helping the world’s poorest build self-sufficiency. As partners, with our varied skills and contributions, we commit to doing our part to:

• Advance R&D through partnerships and provision of funding to find next-generation treatments and interventions for neglected diseases.

• Enhance collaboration and coordination on NTDs at national and international levels through public and private multilateral organisations to work more efficiently and effectively together.

• Enable adequate funding with endemic countries to implement NTD programmes necessary to achieve these goals, supported by strong and committed health systems at the national level.

• Provide technical support, tools and resources to support NTD-endemic countries to evaluate and monitor NTD programmes.

• Provide regular updates on the progress in reaching the 2020 goals and identify remaining gaps.

To achieve this ambitious 2020 vision, we call on all endemic countries and the international community to join us in the above commitments to provide the resources necessary across sectors to remove the primary risk factors for NTDs—poverty and exposure—by ensuring access to clean water and basic sanitation, improved living conditions, vector control, health education, and stronger health systems in endemic areas.

We believe that, working together, we can meet our goals by 2020 and chart a new course toward health and sustainability among the world’s poorest communities to a stronger, healthier future.

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Abbreviations

ACT...............................Artemisinin-based Combination Therapy
ALMA............................African Leaders Malaria Alliance
AMFm............................Affordable Medicines Facility for malaria
APPG.............................All-Party Parliamentary Group
APPMG........................All-Party Parliamentary Group on Malaria and Neglected Tropical Diseases
CHW.............................Community Health Worker
DFID.............................UK Department for International Development
FIND..............................Foundation for Innovative New Diagnostics
GFATM.........................Global Fund for AIDS, Tuberculosis and Malaria
GMAP...........................Global Malaria Action Plan
GPARC.........................Global Plan for Artemisinin Resistance Containment
GPIRM.........................Global Plan for Insecticide Resistance Management
IEC..............................Information Education Communications
IRS..............................Indoor Residual Spraying
ITN..............................Insecticide Treated mosquito Net
IVM..............................Integrated Vector Management
LLIN.............................Long Lasting ITN
M&E..............................Monitoring and Evaluation
MMV..............................Medicines for Malaria Venture
MVI..............................PATH Malaria Vaccine Initiative
NGO..............................Non Governmental Organisation
NMCP........................National Malaria Control Programmes
NTD..............................Neglected Tropical Disease
PDP..............................Product Development Partnership
PMI...............................President’s Malaria Initiative
PPP..............................Public Private Partnerships
R&D..............................Research and Development
RBM.............................Roll Back Malaria Partnership
RDT..............................Rapid Diagnostic Test
SMS..............................Short Message Service
SP.................................Sulphadoxine-pyrimethamine
UNICEF.........................United Nations Children’s Fund
WHO.............................World Health Organisation
Acknowledgements

The APPMG would like to give its thanks to the UK Coalition against Neglected Tropical Diseases chaired by Dr Wendy Harrison, Managing Director, Schistosomiasis Control Initiative, Imperial College for preparing and producing this publication. She was ably helped by members of the Coalition, in producing this Neglected Tropical Diseases Report for the Group.

We would like to thank GlaxoSmithKline which has generously funded the printing of this report.

We greatly appreciate the work and support of the Rt Hon Andrew Mitchell MP, the previous Secretary of State at the Department of International Development (DfID) and by the previous Under-Secretary of State Stephen O’Brien MP for their efforts to control NTDs and malaria. They hosted the London Summit in January when they announced an additional £240 million for funding the control of NTDs.

Especially we would like to put on record our thanks to previous Under-Secretary of State Stephen O’Brien who has been a champion of the control of NTDs and malaria when he was Chairman of the APPMG and during his time as a Minister at DfID.

Speakers who have made valuable contributions to the debate during the past year include:

Senior Professorial Fellow David Molyneux, Centre for Neglected Tropical Diseases, Liverpool
Dr Paul Emerson, the Carter Centre and Professor at the Emory Rollins School of Public Health
Professor Alan Fenwick, the Schistosomiasis Control Initiative
Archana Patel, Sightsavers
Professor Clare Gilbert, International Centre for Eye Health, London School of Hygiene and Tropical Medicine
Dr Lesley Drake Partnership for Child Development Coordinator, Imperial College School of Medicine
Dr Lorenzo Savioli, World Health Organisation
Kathryn Rawe, Save the Children
Dr Franco Pagnoni, WHO/TDR
Gini Williams, TB Project Director, International Council of Nurses
Dr Karin Kallander, Regional Programme Coordinator for the inSCALE Project, Malaria Consortium
Dr Mark Booth - Wolfson Research Institute, Durham University
Paul Ging - Communications Office, Durham University
Neil Hall - Liverpool University
Deborah Smith - York University
Jennifer Cook, Acting Deputy Director Wolfson Research Institute, Durham University
Dr Peter Hotez, President of the Sabin Vaccine Institute leader of the Sabin Vaccine Development Programme, at Texas Children’s Hospital and Baylor College of Medicine
Nine Steensma, Programme manager at the Essential Medicines Team with the Clinton Health Access Initiative (CHAI)
Professor Don Bundy - The World Bank
Professor Mark Taylor, Professor of Parasitology, Director of the A WOL Consortium
Dr Stuart Smith, Developing World Health
Elaine Ireland - Sightsavers

The All-Party Group on Malaria & Neglected Tropical Diseases are also most grateful for financial support from:

- UK Coalition against NTD members (Sight Savers, Centre for NTDs Liverpool, the Schistosomiasis Control Initiative and the Partnership for Child Development at Imperial College and Carter Centre UK)
- Sabine Vaccine Institute Europe
- Medicines for Malaria Venture
- Malaria Consortium
- Malaria No More UK
Introduction

The year of 2012 has been a transformative one for the United Kingdom with London 2012 Olympic and Paralympic Games and the celebration of the Queen’s Jubilee. For the Neglected Tropical Disease (NTD) community there has also been a sea change in the recognition that NTDs represent a major global health priority with far ranging impacts on educational attainment, productivity and mental health. The scale of the problem and the availability of known, cost effective and sustainable solutions, as well as the historic legacy of success combine to make the UK’s investment in NTD programmes excellent value for money.

Environmental and social change also have a significant impact on NTDs particularly those that are vector or water borne. Socio-economic poverty has a direct relationship with NTDs, but so do levels of urbanisation, civil unrest, natural disasters, habitat degradation and more intensive agriculture.

The largest coordinated effort to date to combat NTDs resulted in the signing of the London Declaration in January 2012 in which all major stakeholders including the World Health Organization (WHO) and other UN agencies, national governments and the pharmaceutical industry expanded their support for the control and ultimate elimination of NTDs. At the same meeting the WHO launched a road map to achieve elimination of NTDs “Accelerating work to overcome the global impact of NTDs” which sets out the required steps to consign these ancient diseases to history.

The commitments of the London Declaration cover all aspects of NTD implementation, research and policy. Issues around partnership management, country commitment to match donor resources from national budget lines and ensuring resources reach those in greatest need are amongst the responsibilities assumed by the signatories. The NTD community is committed to being accountable for reaching these elimination goals and striving to coordinate and harmonize efforts by all actors to maximise the efficiency of NTD programmes.

In response to this need for more effective partnership mechanisms, and in the build-up to the January Declaration, the UK Coalition against NTDs (UKCNTD) was launched as a collaborative partnership between UK organisations actively engaged in implementation, capacity building and research in NTDs at scale. The UKCNTD seeks to create a consensus around effective policies and programmes, and with specific aims to

- influence policy strategy and implementation decision-making to best support effective approaches for the long term sustainably control and elimination of NTDs and ensuring that NTDs are included within national regional and international health development frameworks
- leverage resources in support of global NTD control and elimination process
- foster and facilitate communication, collaboration and information sharing between all agencies invested in NTD control

Over 2012 the UKCNTD has been privileged to sponsor the All-Party Parliamentary Group on Malaria and Neglected Tropical Diseases. Strong representation of the communities affected by NTDs remains essential to the elimination effort and the involvement and partnership between the UKCNTD and the APPMG is critical to its success.
Control & Elimination

NTD CONTROL AND ELIMINATION CONTRIBUTES TO THE UK GOVERNMENT PRIORITIES IN INTERNATIONAL DEVELOPMENT AND THE POST 2015 DEVELOPMENT AGENDA

The UK government’s priorities in international development include achievement of the Millennium Development Goals (MDGs); ensuring international development aid delivers value for taxpayers’ money, and poverty alleviation. The leadership the UK government has shown in supporting the global effort towards the elimination of NTDs, through meeting their G8 commitments on NTDs and the significant financial commitments DFID recently made towards reducing the burden of NTDs all contribute to supporting these priorities.

Eradicating extreme poverty and hunger

NTDs are diseases of poverty. 1 in 6 people globally are currently infected by NTDs and another two billion people are at risk of the debilitating effects of these diseases including chronic pain, blindness, severe disability, disfigurement, and malnutrition. NTDs can limit the economic productivity of workers who are infected and prevent children from going to school, locking families in a cycle of poverty. There is a strong link between nutrition and NTDs. NTDs exacerbate undernutrition by causing loss of nutrients and in turn, undernutrition can increase susceptibility to infection with NTDs. Parasites such as hookworm consume nutrients from food ingested by an infected person, depriving them of essential nutrients and potentially minimising the impact of supplements or food aid in emergency situations.

Achieving universal primary education

Over half a billion children throughout the world are infected by NTDs. These diseases can have a negative impact on a child’s cognitive and physical development and can prevent them from attending school and learning. Children not infected with NTDs may also miss out on learning if they are needed to stay home to care for family members who are sick or disabled due to NTD infections. Interventions such as school deworming are simple, safe and cost-effective. Deworming costs less than US$0.50 per child per year and can improve the health and education of millions of children.

Promoting gender equality and empowering women

NTDs can impact on women’s sexual and reproductive health and their economic and social well-being. For diseases such as trachoma; women face increased risk of infection—they are almost twice as likely as men to develop the advanced stage of the disease, which can lead to painful disability or blindness. Their roles as primary carers and water collectors can increase their exposure to diseases that can be easily spread through contact with dirty faces or infected water sources. Women with female urogenital schistosomiasis (FGS) have three times the chance of contracting HIV than those women without it in Africa, at least 16 million women may be infected with FGS. NTDs like onchocerciasis, trachoma and lymphatic filariasis can cause disabilities such as blindness or severe swelling of the limbs making it difficult for women to work or care for their families putting them at risk of marginalisation and stigmatisation.

Reducing child mortality rates and improving maternal health

 Mothers and children are disproportionately affected by NTDs, leading to increased maternal morbidity and mortality, poor pregnancy outcomes, and impairment of childhood development. Chronic hookworm infection and schistosomiasis are major causes of anaemia and combined with anaemia caused by malaria, they can cause serious complications during pregnancy and childbirth including low birth weight, which can be a risk factor for neonatal and infant mortality and morbidity.
Combating HIV/AIDS, malaria, and other diseases

NTDs weaken the immune system, putting infected individuals at higher risk of contracting other diseases and impairing their ability to resist infection. Recent research has indicated that NTDs can have negative impacts on efficacy of treatment for other diseases such as HIV & TB and can also increase the risk of opportunistic infections in people living with HIV.

Significant levels of co-infection offer opportunities for integrated treatment programs that strengthen primary health care and other disease interventions; ensuring that they are as effective as possible. For example, supporting community drug distributors who provide ivermectin for onchocerciasis, and to distribute Vitamin A for night blindness a vitamin deficiency disease and insecticide-treated bed nets can significantly increase the use of these nets which can interrupt the transmission of lymphatic filariasis (and possibly other NTDs) as well as malaria.

Sustainable access to safe drinking water and basic sanitation

Improved, provision of safe water supplies, sanitation and hygiene (WASH) is essential to prevent infectious disease in the world’s poorest countries. WASH plays a role in the spread, control or management of 13 NTDs. Women, children, fishermen and farmers all face increased risk of water related NTDs due to their daily proximity to potential unsafe water sources and continued exposure to environmental contamination as a result of poor sanitation. 2.5 billion people globally lack access to improved sanitation, and more than 1 billion practise open defecation. Strong community WASH practices can help to break the cycle of infection for diseases such as trachoma, soil transmitted helminths and schistosomiasis as well as many diarrhoeal diseases. Encouraging the washing of children’s faces, improving access to safe water, and proper disposal of human and animal waste has been shown to decrease the number of trachoma infections in communities and is a key intervention in the programme to eradicate Guinea Worm. According to WHO, improving WASH can reduce trachoma by 27 per cent and improved sanitation could reduce schistosomiasis by as much as 77 per cent. The integration of WASH and NTD programmes is crucial to achieving sustained control and elimination of the WASH-related NTDs.

Value for money

Programmes designed to control NTDs are among the most cost effective in public health and many NTDs are highly cost-effective to treat. The public-private partnerships in NTDs have led to the biggest single health venture in the history of disease control. Over 700 million treatments are now administered annually for the control and elimination of NTDs in more than 80 endemic countries. The combination of major pharmaceutical product donations and school based and community distribution through mass drug administration has empowered communities to lead control and elimination activities meaning that five of the NTDs cost as little as 5 pence per treatment. For guinea-worm eradication, onchocerciasis control and lymphatic filariasis elimination, calculations of the economic return on investment have been shown to range from 15% to 30%, among the highest in health.

A new Framework: Post 2015

With the selection of David Cameron as one of the 3 co-chairs of the UN High Level Panel on Post-2015, the UK government is now starting to develop work on what should be included in the successor framework to the MDGs. NTDs, with their huge impact on the poorest populations in the world have received recent attention as part of efforts to make progress towards MDG 6. In developing the successor framework to the MDGs, it will be important for the UK government to determine how current commitments to NTDs can be maintained within the next global development framework. Of particular importance will be the need to ensure commitments to support the strengthening of systems that need to be in place to prevent, control and eliminate NTDs and enable the poorest of the poor (including the 1 billion people impacted by NTDs) to have equitable access to good quality health services recognising that affected populations are currently those with the least access to care.
Increased Commitment

2012 HAS SEEN AN UNPRECEDENTED INCREASE COMMITMENT FROM THE UK GOVERNMENT AND OTHER DONORS TO SUPPORT NTD CONTROL AND ELIMINATION

In recent years, governments, principally in the UK and the USA, have recognized the cost effective impacts of supporting NTD control. The US Agency for International Development (USAID) has committed US$212 million since 2006 and the previous UK government pledged £50 million. However at a meeting organised by the Bill & Melinda Gates Foundation (BMGF) in January 2012 DFID announced a further £240 million over four years, which will supply more than four treatments every second for people living in poverty in the developing world. This meeting was the largest coordinated effort to date to combat NTDs was attended by Bill Gates, past Under-Secretary of State Stephen O’Brien, Dr. Ariel Pablos-Méndez, Assistant Administrator for Global Health, USAID, Dr Margaret Chan, Director General of the WHO, Dr Caroline Anstey, Managing Director of the World Bank and Chief Executives of 13 major pharmaceutical donors.

Increased drug donations

These pharmaceutical company donors are committed to greatly increase the numbers of drugs donated to support the control or elimination of NTDs. The announcement of new donations included companies who made commitments for the first time to NTD control or elimination as well as expanded donations from existing donor companies. For example, GlaxoSmithKline already donates nearly 2 billion tablets of albendazole for lymphatic filariasis and will continue until elimination is achieved. It will also provide 400 million tablets a year until 2020 to de-worm school-age children in Africa. Johnson and Johnson increased their annual donation of mebendazole to 200 million tablets every year while Novartis is continuing its commitment to providing multi-drug therapy against leprosy. Pfizer will continue its donation of drugs for binding trachoma until at least 2020, as well as donating the drug and a placebo for a study on the reduction in mortality of children treated with that drug. Merck KGaA increased their commitment from 50 to 250 million tablets for treatment of schistosomiasis. Sanofi, Merck Sharp and Dohme and various other companies are also providing major drug donations. The value of these donations is estimated to be of the order of some $1-2 billion annually.

Government, International agency and research and development support

USAID also announced an $89 million appropriation by the US Congress to strengthen drug delivery and distribution programmes. In addition, the World Bank agreed to extend its financing and technical support to help African countries build stronger community health systems that will integrate NTD elimination and control, as well as work with other partners to expand a trust fund to combat onchocerciasis to other preventable NTDs in Africa.

BMGF committed US $360 million for operational research for NTDs and for research into the development of new products including vaccines over the coming years. This is particularly important for diseases that require individual intensified case management for which affordable, effective and safe drugs are not yet routinely available.

Support to achieve the eradication of Guinea Worm

Guinea Worm, together with polio, is a disease which WHO has committed to eradicate. The London meeting marked the close of the funding gap for Guinea worm eradication, His Highness Sheikh Khalifa bin Zayed Al Nahyan, President of the United Arab Emirates, the BMGF, and the Children’s Investment Fund Foundation committed to donate US$40 million to The Carter Centre. These commitments complemented a £20 million pledge from DFID as part of their larger investment to NTDs. There are now only four countries endemic for the disease and just over 1000 cases were reported in 2011. The Director General of the WHO, Dr Margaret Chan commented that “the efforts of WHO, researchers, partners, and the contributions of industry have changed the face of NTDs. These ancient diseases are now being brought to their knees with stunning speed. With the boost to this momentum, I am confident almost all of these diseases can be eliminated or controlled by the end of this decade.”

A community member holds out their Metizan treatment in Kachia in Kaduna state Nigeria. Source: Kate Holt, Sightsavers
Significant Changes

There have been significant changes in the delivery paradigms with convergence of efforts essential as programmes move from control to elimination.

The past five years have seen a considerable increase in access to preventive chemotherapy (PCT) against key neglected tropical diseases. The focus for the initial years of integrated NTD programmes has been to focus on those diseases for which there are effective and safe drugs that can be administered without the need for individual diagnosis. While this strategy has had considerable impact on the global burden of disease for some NTDs, there is a need to consolidate the gains and ensure that systems are in place to allow these populations to remain free from NTDs in the future through effective surveillance.

Integration into primary health care approaches

The principles of primary health care are now being considered when planning all disease prevention and control activities: active community participation, an integrated health service delivery system, and actions to address the broader social determinants of health. The rapid scale up of PCT and delivery through NTD-specific programmes operating parallel to weak and ineffective health systems was necessary in the short term to allow a rapid reduction in the burden of disease. However, sustainable NTD control will aim to integrate into a primary health care approach. The first step will be for greater integration between disease-specific programmes, and an improved linkage with the health system in order to support on-going strengthening and improvement of existing national health systems, including supply chain management, training, supervision and information management. Collaboration between NTD and malaria prevention and control programmes is practical on several counts:

- **Similar locations and populations are at risk**

There is significant geographical overlap of the diseases and it is often the same groups within the population who are most at risk of harbouring these infections and of experiencing the consequences of infection; these are often the poorest people and those with the least access to formal health services. There is also opportunity to build upon existing, successful NTD and malaria campaign activities to provide other services to these underserved populations. This could involve vaccination catch-up for infants, provision of replacement insecticide-treated bed nets, or dissemination of key health education messages.

- **Infection with some NTDs can influence risk or severity of malaria**

In people co-infected with both malaria and hookworm, both infections contribute to anaemia and are particularly serious in children and pregnant women. Chronic anaemia during childhood can have negative effects on growth, cognitive development and school performance, perpetuating the cycle of neglect and poverty for these populations. In pregnant women severe anaemia is associated with maternal mortality and low birth weight babies.

- **Similarities in delivery mechanisms for some interventions**

Since both disease control strategies are specifically designed to access the hard to reach and neglected populations there is opportunity to combine resources and to share best practice to strengthen distribution systems. A further area that warrants consideration is improved surveillance systems designed to support countries with declining malaria incidence being adapted to apply also to epidemic-prone NTDs such as visceral leishmaniasis. There is also the possibility to opportunistically integrate PCT against specific NTDs into routine malaria activities. An example would be deworming pregnant women during their antenatal visits for intermittent preventive treatment of malaria, and concurrent deworming of any children who attend the clinic with their mother.
Convergence of efforts with water and sanitation actors

Water, sanitation and hygiene (WASH) are a crucial but all too often an underplayed part of the prevention and control of NTDs. Diseases including trachoma, STH and schistosomiasis demand practical WASH interventions so that their prevention, treatment and ultimately their elimination can be achieved by the international community as soon as possible. Part of the slow progress in achieving integration between the WASH and NTD sectors could be attributed to the approaches that have been undertaken to date. Better integration could be achieved by developing partnerships between agencies implementing NTD programmes and agencies implementing WASH, sharing knowledge including the current WASH best practice and making a significant commitment to long-term planning and implementation.

Very few organisations that are highly experienced in NTD programming have a similar level of expertise in the area of WASH. Similarly, WASH programmes are often implemented without consideration of the burden of NTDs within a particular service delivery area, nor are they evaluated in terms of their impact on disease reduction. This means that the two sectors and the agencies within them operate towards a different set of goals. Given the complexity of WASH interventions and the existing availability of WASH expertise, developing effective partnerships between NTD and WASH organisations is a pragmatic approach. Such a partnership requires a fundamental shift from traditional NTD vertical programming through MDA to horizontal programming that integrates the activities of the WASH, health and education sectors to construct a holistic and comprehensive approach to NTD prevention and control. The ad hoc delivery of WASH interventions by non-WASH agencies can lead to the use of approaches no longer commonly engaged by specialised agencies, or approaches that directly contradict recent learning on good practice WASH programming. The NTD sector has developed robust private sector relationships with pharmaceutical companies who have contributed billions of dollars’ worth in donated products each year to help treat NTDs. Private sector involvement in WASH activities as part of an NTD programme has not been extensive to date, and sharing this integration conversation with this important actor may also help to drive the prevention and control activities further.

A pupil using a leaky tin to wash their hands and face to prevent trachoma in Kajiado Kenya.
Source: Kate Holt, Sightsavers
Convergence of efforts with the animal health sector

Zoonotic diseases (infections from animal sources) represent some 70% of infections of humans. Whilst the pandemic threats of avian influenza, SARS, Hantavirus and Ebola frequently grab the headlines the chronic infections, known as the neglected zoonotic diseases (NZDs), of those communities whose livelihoods are dependent on livestock create a huge double burden on human and animal health. 600 million people are estimated to be dependent on livestock as their source of food and income—often their only cash asset. Mortality or reduced production of livestock at a time of family illness can often overwhelm the fragile coping mechanisms of communities and trap them in a cycle of poverty.

The NZDs are frequently misdiagnosed increasing the likelihood of severe disease due to inappropriate treatment in those that do have access to any health service or facility.

There is increasing interest in strategies that recognise the multifactorial nature of human health status and aim to engage with veterinary public health actors to affect a more comprehensive approach to disease management and control. In addition veterinary health workers can often be the most medically qualified personnel in an area and can be engaged to deliver human medicines, services and education and undertaken disease surveillance for a range of diseases alongside their animal health duties.

Utilisation of effective technology

Throughout WHO member states, 5 billion wireless subscribers exist; with over 70% living in low- and middle-income countries. The ubiquitous nature of mobile phone networks surpasses other tangible infrastructures and offers huge potential for use in health care.

Mobile phone platforms are already used to monitor disease prevalence and track disease outbreaks. NTDs such as Chagas, dengue and leishmaniasis are benefiting from rapidly improved disease reporting allowing officials to obtain quality data in real time and improve response to disease outbreaks in remote regions. There is also a role for mobile technologies in diagnostics allowing health workers in rural areas access to information and advice from specialists located in distance referral hospitals. The potential to simplify the NTD diagnostic tests so that health workers can accurately perform state-of-the-art diagnosis using handheld devices is also slowly being realized.

Using existing mobile phone capacity to disseminate information on disease prevention and increasing awareness of treatment campaigns is already being employed to great effect in other diseases areas and offers exciting possibilities for NTD control and elimination. Such initiatives are spreading and transforming the way health services and information are accessed, delivered, and engaged; allowing health care infrastructure to exist in the most inaccessible areas.

Significant Changes

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There has been a rapid expansion in research on NTDs over the past decade as highlighted in a report published this year by Thomson Reuters and in a Global Research Report published by WHO/Tropical Disease Research (TDR). However, whilst there has been an increase in scientific papers focused on NTDs, as a proportion of the global research resources there is a significant discrepancy between the burden of NTDs and the populations affected compared with the traditional diseases of the rich countries such as diabetes and cancers as well as HIV/AIDS.

With several NTDs not having safe and effective treatments available and with other diseases moving from the control to the elimination approach there is a greater need for increased investment in both basic and applied research. There is also a need to promote research ownership with enabling policies in disease endemic countries. Countries in which these diseases occur need a central role in defining research priorities. However, there is a critical issue of the need for increased national commitment to research and hence national capacity. Interventions may also be setting specific and hence research is needed to define the most effective interventions nationally or regionally whilst policy must be more rapidly translated into practice. Large programmes need to have embedded implementation, research and country capacity building.

**OPERATIONAL RESEARCH SUCCESSES**

A laboratory set up in a school classroom in Malawi. Source: Schistosomiasis Control Initiative (SCI)
## Fact sheets on common NTDs

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<thead>
<tr>
<th>NTD</th>
<th>Symptoms disability caused</th>
<th>Number of people at risk globally a</th>
<th>Global DALY burden</th>
<th>Current Method of treatment and prevention</th>
<th>Target for control elimination and target year to be eliminated</th>
<th>Percentage of at risk population receiving treatment b</th>
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<tr>
<td>Chagas Disease</td>
<td>The disease is caused by a protozoan transmitted through contact with the faeces of an insect the triatomine bug known as the “kissing bug” and can also be transmitted through blood transfusion and organ transplant. Without treatment, is potentially fatal following cardiac and intestinal complications.</td>
<td>100 million people are at risk worldwide. Chagas disease is endemic in 21 countries across Latin America and patient numbers are growing in non-endemic countries such as the United States, Australia, and Europe.</td>
<td>430,000 Disability Adjusted Life Years. Existing treatments have an unsatisfactory cure rate and can have toxic side effects. There is a great need to develop new treatments for this disease.</td>
<td>The WHO Roadmap for Implementation sets a target of regional elimination of transmission through blood transfusions by 2015 and intra-domiciliary transmission in the region of the Americas by 2020.</td>
<td>Only a small proportion of infected people receive appropriate treatment.</td>
<td></td>
</tr>
<tr>
<td>Human African Trypanosomiasis (HAT)</td>
<td>HAT is caused by a parasite transmitted by the tsetse fly which invades the nervous system and causes mental deterioration and other neurologic problems and is fatal without treatment.</td>
<td>60 million people are at risk of being infected in 36 African countries.</td>
<td>1.673,000 Disability Adjusted Life Years. Up until 2009, existing treatments for stage 2 of the disease were toxic or difficult to administer. In 2009, DNDi and its partners launched the first new treatment for HAT in 25 years.</td>
<td>The WHO Roadmap for Implementation sets a target of country elimination in 80% of affected foci by 2015.</td>
<td>Only a small proportion of infected people receive appropriate treatment.</td>
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<tr>
<td>Leishmaniasis</td>
<td>The parasite that leads to infection is Leishmania and transmitted by sand flies. Leishmaniasis has several different forms; visceral leishmaniasis, which is fatal without treatment, and cutaneous leishmaniasis are the most common causing disfigurement and stigma.</td>
<td>350 million people living at risk worldwide. Leishmaniasis occurs in 98 countries.</td>
<td>1.974,000 Disability Adjusted Life Years. Existing treatments are difficult to administer, toxic, and costly. Drug resistance is also an increasing problem. There is a great need to develop new treatments for these diseases.</td>
<td>The WHO Roadmap for Implementation sets a target of Regional elimination for visceral Leishmaniasis on the Indian subcontinent by 2020.</td>
<td>Only a small proportion of infected people receive appropriate treatment.</td>
<td></td>
</tr>
<tr>
<td>Leprosy</td>
<td>Caused by Mycobacterium Leprae. The disease attacks the skin and nerves and can lead to irreparable nerve damage, impairments and disabilities affecting hands, feet and eyes.</td>
<td>The number of new cases of Leprosy detected during the year 2011, was 219,075. These cases were reported by 105 countries.</td>
<td>194,000 Disability Adjusted Life Years. 220,000 new cases in 2011. India, Brazil and Indonesia account for 83% of new cases in 2011. An estimated 2-3 million remain with WHO Grade 2 (visible) disability but comprehensive disability statistics are unreliable.</td>
<td>6 or 12 months Multiple Drug therapy (MDT) depending on classification of disease. Early diagnosis and treatment is the best prevention of disability. Prevention— Bacillus Calmette–Guérin (BCG) vaccine provides some protection and trials are also underway to roll out chemoprophylaxis using single dose rifampicin for close contacts.</td>
<td>WHO Global target of elimination as a public health problem (prevalence of less than one case per ten thousand population) was achieved by 2000. Current WHO Global Strategy 2011-2015 and recommendation of WHO Expert Committee (2010) set targets as reduction of grade two disability rate per 100,000 population by 35% by 2015 and global goal of reducing to one new case of leprosy with Grade Two disability (visible) per million population by 2020.</td>
<td>Over 15 million treated since introduction of Multiple Drug Therapy in early 1990s although coverage with MDT for all new cases is still difficult in hard to reach populations in areas of conflict, nomadic populations and urban slums. Even once treated, many remain at risk of further disability, stigma and discrimination.</td>
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<tr>
<td>Lymphatic Filariasis</td>
<td>Severe intermittent fever. Clinical manifestations include hydrocele (severe swelling of the scrotum) and lymphoedema (swelling of the lower limbs).</td>
<td>1,393 million people living at risk worldwide.</td>
<td>5,941,000 Disability Adjusted Life Years.</td>
<td>Annual preventive chemotherapy with either diethylcarbamazine citrate (DEC) and albendazole or ivermectin and albendazole in countries co-endemic for onchocerciasis for at least 5 years. Morbidity management through hygiene of affected limbs and hydrocele surgery. Integrated vector control.</td>
<td>The WHO Roadmap for Implementation sets a target of elimination of lymphatic filariasis as a public health problem by 2020.</td>
<td>41.8% of people at risk currently receive treatment. 73 countries endemic for LF. 538 million people treated in 2011. 53 countries have national programmes with 12 in post surveillance phase.</td>
</tr>
</tbody>
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a. [Fact sheets on common NTDs](http://www.who.int/ntd/publications/2010/9789241564090_1g.pdf)

b. [Fact sheets on common NTDs](http://www.who.int/ntd/publications/2010/9789241564090_2g.pdf)
<table>
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<tr>
<th>NTD</th>
<th>Symptoms disability caused</th>
<th>Number of people at risk globally</th>
<th>Global DALY burden</th>
<th>Current Method of treatment and prevention</th>
<th>Target for control elimination and target year to be eliminated</th>
<th>Percentage of at risk population receiving treatment</th>
</tr>
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<tr>
<td>Onchocerciasis</td>
<td>Caused by a parasitic worm that is spread by the bite of a black fly. It can cause blindness as well as debilitating skin conditions including intense itching and skin depigmentation.</td>
<td>123 million people living at risk worldwide.</td>
<td>389,000 Disability Adjusted Life Years.</td>
<td>Treatment of communities at risk of transmission (formerly hyper and meso endemic) by annual community directed treatment with ivermectin.</td>
<td>The WHO Roadmap for implementation sets a target of elimination of transmission using ivermectin by 2020 in selected African countries and in the endemic foci in Latin America by 2015. Elimination of all transmission in Africa by 2025.</td>
<td>65.7% of people at risk currently receive treatment.</td>
</tr>
<tr>
<td>Schistosomiasis</td>
<td>Repeated infection with schistosomes can lead to anemia, malnourishment, and learning difficulties in children. After years of infection, the parasite leads to severe damage of the liver, intestines, lungs, and bladder.</td>
<td>236 million people living at risk worldwide.</td>
<td>1,707,000 Disability Adjusted Life Years.</td>
<td>Preventative Chemotherapy with Praziquantel (40mg/kg) and improved water sanitation and hygiene. There are also ongoing studies to develop a vaccine against schistosomiasis.</td>
<td>The current WHO Global Strategy for Schistosomiasis 2011-2015 is: To control morbidity of schistosomiasis by 2020. To eliminate schistosomiasis as a public health problem by 2025. To interrupt transmission in selected regions by 2025.</td>
<td>13.1% of people at risk currently receive treatment.</td>
</tr>
<tr>
<td>Soil-Transmitted Helminths</td>
<td>Infestations with 4 species of nematodes are collectively referred to as soil-transmitted helminthiases: Morbidity is related to the number of worms harboured. People with light infections usually have no symptoms. Heavier infections can cause a range of symptoms including intestinal manifestations (diarrhoea, abdominal pain), general malaise and weakness, and impaired cognitive and physical development. Hookworms cause chronic intestinal blood loss that can result in anaemia.</td>
<td>890 million people living at risk worldwide.</td>
<td>4,013,000 Disability Adjusted Life Years.</td>
<td>Preventative Chemotherapy with Abendazole or Mebendazole and improved water sanitation and hygiene. There are also ongoing studies to develop a vaccine against hookworm.</td>
<td>The current WHO Global Strategy for soil-transmitted helminthiases from 2011-2020 is: To control morbidity through the periodic treatment of at-risk people living in endemic areas. The global target is to regularly treat at least 75% of all school-age children at risk of illness from soil-transmitted helminths by 2020. Progress made by each country is measured against this target.</td>
<td>31.1% of people at risk currently receive treatment.</td>
</tr>
<tr>
<td>Taeniasis/ Cysticercosis</td>
<td>Taeniasis/Cysticercosis is a parasitic diseases that is caused by eating of infected under cooked pork. The parasite develops into a tapeworm (taeniasis) in the gut of humans causing intestinal disorders but also the parasite can invade other organs (cysticercosis) including the nervous systems and cause neurological problems including epilepsy and can be fatal.</td>
<td>50 million people worldwide are affected.</td>
<td>No global figures for Disability Adjusted Life years are currently available.</td>
<td>Treatment is with anti-epileptic treatments for neurological conditions and praziquantel and niclosamide for the tapeworm. Also confinement of pigs and increased food hygiene combined with improved sanitation prevent the spread of taeniasis/cysticercosis.</td>
<td>No elimination target has been set for taeniasis/cysticercosis.</td>
<td>Only a small proportion of infected people receive appropriate treatment.</td>
</tr>
<tr>
<td>Trachoma</td>
<td>A bacterial infection that causes repeated conjunctivitis. Repeated infections can turn the eyelid inwards making the eyelashes scratch the surface of the eyeball (trichiasis). Prolonged scratching of the cornea by the eyelashes can lead to irreversible blindness. Trachoma is the world’s leading cause of preventable blindness.</td>
<td>281 million people living at risk worldwide.</td>
<td>1,334,000 Disability Adjusted Life Years.</td>
<td>WHO recommended SAFE strategy (Surgery of eyelids, Antibiotics to treat the community pool of infection, Facial cleanliness to reduce transmission and Environmental improvements) to reduce the number of flies people come into contact with. The WHO recommends 2 antibiotics for trachoma control oral azithromycin and tetracycline eye ointment.</td>
<td>The WHO Roadmap for Implementation sets a target of elimination trachoma as a public health problem by 2020.</td>
<td>13.1% of people at risk currently receive treatment.</td>
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Jeremy Lefroy (Stafford) (Con): It is an honour, Mr Williams, to serve under your chairmanship.

I declare an interest as the chairman of the All-Party Group on Neglected Tropical Diseases. NTDs are a group of diseases that affect more than 1 billion people around the world. They do not have the high profile of malaria, HIV/AIDS or TB—hence the word “neglected”—but they result in disability and death. Even for those who are less seriously affected, they bring chronic conditions that mean loss of income. Such diseases include worms or helminths, schistosomiasis or bilharzia, trachoma, lymphatic filariasis or elephantiasis, and leprosy.

Almost without exception, NTDs are diseases of the poor. They are also curable. The World Health Organisation’s 2010 report found that approximately 90% of their burden can be treated with medicines administered only once or twice a year, and that can sometimes be achieved for as little as 50 US cents. Treating and eradicating those diseases must be at the heart of any programme to tackle poverty.

Yet as the title of the debate makes clear, they have been neglected for many years. Institutes such as the Liverpool and London Schools of Tropical Medicine, Imperial College London and the Antwerp Institute of Tropical Medicine, working with researchers and institutes in developing countries, have made great strides in the understanding and treatment of NTDs.

Drug companies have also made a great contribution, working with bodies such as the Bill and Melinda Gates Foundation. On the day when the UK announced a fivefold increase in its funding commitment to tackle NTDs as part of a global partnership, all drug companies with NTD drug donation programmes pledged to sustain, extend or increase their programmes to the end of the decade.

For example, GlaxoSmithKline has already donated nearly 2 billion tablets of albendazole for lymphatic filariasis and will continue until elimination is achieved. It is also providing 400 million tablets a year free of charge until 2020 to de-worm school-age children in Africa. Johnson and Johnson is increasing its annual donation of mebendazole to 200 million tablets every year—again, to tackle worms. Novartis is continuing its commitment to providing multi-drug therapy against leprosy in a final push against the disease. Pfizer will continue its donation of drugs for blinding trachoma until at least 2020, as well as donating the drug and a placebo for a study on the reduction in mortality of children treated with that drug. Sanofi, Merck and various other companies are also providing major drug donations.

It is not only drugs that are important, but vaccines. The Sabin Vaccine Institute, in which I declare an interest as a trustee of its UK charitable body, is developing vaccines to treat NTDs around the world.

I will come to the reasons why it is important—particularly with regard to efficiency in the use of aid money, which is a major public policy question.

In recent years, Governments, principally in the UK and the USA, have begun seriously to fund work on NTDs. In the UK, this began under the previous Government with an allocation of £50 million. Earlier this year, the Department for International Development announced a further £240 million over four years, which will supply more than four treatments every second for people in the developing world. I pay tribute to the Secretary of State and his predecessor for recognising the importance of this work. We are especially fortunate because the Minister—I am delighted that he will respond to this debate—has been a champion in the fight against NTDs, both when he was chairman of the all-party group and subsequently as Minister.

We have come a long way in tackling such diseases in the past decade. The number of new cases of leprosy reported to the WHO has fallen every year since 2002 from 620,000 to 249,000 in 2008. The number of new cases of human African trypanosomiasis.
pharmaceutical companies have been in tackling both how closely involved and how generous several heartened, as chairman of the all-party group, to see.

Finally, we need to support research. I have been committed under the Abuja declaration. Secondly, we need to support the countries in which NTDs are endemic, to strengthen their health systems. The most important thing I have learned in the past year as chairman of the all-party group is that it is only through effective grass-roots health systems with committed, trained staff, often backed by community volunteers, that the fight against NTDs is sustainable.

At the same time, I should like DFID to encourage other countries to begin or increase support for the work. The USA has been a reliable funder, for which we are grateful. It would be most welcome if it, too, could commit to stable amounts over several years. Then there are donors who have yet to contribute to the work. Will the Minister report on what he is doing to encourage others into the fold?

Secondly, we need to support the countries in which NTDs are endemic, to strengthen their health systems. The most important thing I have learned in the past year as chairman of the all-party group is that it is only through effective grass-roots health systems with committed, trained staff, often backed by community volunteers, that the fight against NTDs is sustainable. One-off treatment campaigns can be effective, and are necessary where systems are weak or do not exist, but the effects will fade unless they are backed up by permanent staff and clinics.

The UK has considerable expertise in working with developing countries to strengthen their health systems, but it is vital that the countries themselves meet their commitments, under the Abuja declaration, to spend 15% of their total budget on health. Few are doing that. I would like the Minister to let hon. Members know what the Government are doing to encourage our partner Governments in those countries to keep to their commitment under the Abuja declaration.

Finally, we need to support research. I have been heartened, as chairman of the all-party group, to see both how closely involved and how generous several pharmaceutical companies have been in tackling NTDs in the way I have outlined. However, we need to work closely with them and the research institutes in the UK and elsewhere to ensure that there is a pipeline of effective drugs for all the relevant diseases. Developing drugs and vaccines and bringing them to market is costly; those who suffer from NTDs cannot afford prices that reflect the cost of the research and development. However, although the market may not justify the cost of R and D, common humanity does, and that is where the British people, through DFID, can make a huge contribution.

We often speak about DFID doing this or the British Government doing that, but it is not they but the British people who are making the work possible, by their commitment to international development. I know that the voices raised against are often loud, but in my constituency of Stafford I have met thousands of people who give up their time and money to support projects around the world—schoolchildren, scouts, guides, community groups, churches and others. When the British people see how it is their support, through donations and taxes, that is helping to improve the lives of millions suffering from NTDs, they should know that they are an essential part of that great endeavour.

The past Parliamentary Under-Secretary of State for International Development (Mr Stephen O’Brien):

I congratulate my hon. Friend the Member for Stafford (Jeremy Lefroy) not only on securing this important debate but on his relentless and consistent commitment to the improvement and survival of all vulnerable people, and in particular children, in many parts of the planet. His commitment, both in his life before Parliament and since taking over the chairmanship of the all-party group on malaria and neglected tropical diseases, carries huge influence and is much appreciated by parliamentarians across the House.

This debate comes at an important moment. While being gracious enough to acknowledge his generous words, I hope that he will be the first to admit that the effort to tackle neglected tropical diseases is very much a combined and collective one. Many people have worked over many years to address this issue, which is one of the most tangible issues that our generation can get to grips with in the field of preventable, avoidable and treatable diseases. NTDs have struggled to compete against the three best-known diseases—HIV/AIDS, tuberculosis and malaria—because they often do not kill. Nevertheless, they impede and imperil the quality of life and well-being of many people in many parts of our planet.
I shall begin by setting the debate in a bit of context, from the coalition Government’s perspective, and I shall then seek to answer Members’ questions. When we came into office a couple of years ago, we made it clear that we wanted to build a different style of international development, one based on dynamic partnerships as well as on the relentless pursuit of results and value for money in the Department’s work. I think that it is accepted as common ground, both here and across the House, that the tackling of global disease, particularly tropical and not least neglected diseases, represents value for money. Our vision for controlling NTDs involved marshalling the evidence that NTD programmes deliver results, to justify increasing our investment considerably over the next few years. We were certainly encouraged and influenced by the very positive reports from across the NTD world, including from our pharmaceutical company partners, the World Health Organisation, the Bill and Melinda Gates Foundation, and indeed the United States Agency for International Development, which was rightly referred to by my hon. Friend.

The UK’s experienced and respected academic community has encouraged us to relentlessly do more. I well remember the many representations that I received when I occupied the chair of the all-party group on malaria and neglected tropical diseases, which my hon. Friend now occupies. The UK academic community’s conviction was, and remains, infectious and undiminished, and I found that their information was an enormously useful body of information to carry with me into office as a Minister.

The coalition Government’s determination to achieve the UN’s target for official development assistance spend of 0.7% of GNP, and to do that by demonstrating life-changing and transformative results to the British public, provided the bedrock for the decision that we have taken. Our conclusion was that a significant increase in the level and scope of our involvement was warranted to improve health outcomes and to reduce poverty, while ensuring value for money in achieving those results.

As my hon. Friend has already said, last October at a joint event with President Carter—whose own personal commitment in this sector has been undoubted throughout his post-presidential career—I pledged that the UK would increase its support to trying to achieve guinea worm eradication by 2015 if others stepped up and were able to help to close the financing gap. The challenge was met in January, when the Bill and Melinda Gates Foundation, His Highness Sheikh Khalifa bin Zayed Al Nahyan, who is the President of the United Arab Emirates, and the Children’s Investment Fund Foundation pledged enough money to close that financing gap.

That was important because, as my hon. Friend indicated, it is necessary to seek to encourage others. It is not just a question of seeking, as it were, to impose any kind of leadership or leverage; it is actually about how we get the best collective effort. That will be the most sustainable part of the process in the future, rather than continually having to renew funding.

That exercise in January was really helpful and it has given us great encouragement in this field. Although it is, of course, early days on the road to 2015, it is not so early that we do not need to make progress. So far this year, the results have indeed been impressive. Only in South Sudan has there been any reported cases of guinea worm this year. There have been 143 cases there, which represents a reduction of 62% compared with the same period last year. Of course that is good news, but we should remain aware of the considerable difficulties of operating in many of the affected countries as we aim to maintain the strong progress that has been achieved so far.

On 21 January, we announced increased support for NTD control measures. That increased support has strengthened the UK’s partnerships with the WHO, with foundations, with other donors and with pharmaceutical companies that make drug donations—donations that are much appreciated and hugely valuable—as well as with the endemic countries and indeed with NGOs. As well as guinea worm eradication, the UK’s NTD package comprises five distinct but integrated strands; I will repeat them, although they were accurately described by my hon. Friend.

We will increase support to fight the other diseases that we are already working to combat, which are lymphatic filariasis, onchocerciasis, schistosomiasis and soil-transmitted helminths.

We will conduct more research, which is absolutely critical. Research was one of the issues that my hon. Friend raised. That research will build on the back of a fantastic track record of research around the world, not least in this country, where we have global centres of excellence. I had the honour and the privilege to be the vice-chairman, in a voluntary capacity, of the Liverpool School of Tropical Medicine, where I saw such research for myself. The London School of Tropical Medicine, other London universities and colleges and many other institutions around the country also carry out research.

We have been seeking to strengthen the capacity of the WHO’s NTD department itself, and now we are able to do so. There are new programmes to
control trachoma and visceral leishmaniasis, and an integrated programme approach to tackle a range of NTDs in two high-burden countries because, as my hon. Friend is well aware, there are quite a number of opportunities for synergies in tackling a number of diseases, where one can graft on to the back of some of the interventions for HIV/AIDS, and particularly for TB and malaria, not least because of the bed nets.

In many respects, referring to that issue is a way that I can answer the essential question put by the hon. Member for Mid Derbyshire (Pauline Latham); I am grateful to her for her contribution to the debate. She asked if the global health fund could be extended to tackle NTDs. It is fair to say that even in the current circumstances, which she acknowledged are an impediment, the fund’s focus is on HIV/AIDS, malaria and TB, and even if there were not the current financial readjustments, which we hope will give us a stronger position to go forward and sustain what the fund is best at doing and what it has been tremendously successful at doing in the last 10 years, a focus on NTDs could be a distraction and could start diluting the fund’s efforts, particularly through the country co-ordinating mechanisms, which are the essential mechanism through which delivery is made at country level. What will be important, however, is to look at whether we can give a greater sense of purpose and instruction to the way in which the country co-ordinating mechanisms work to see where those synergies can be captured. In that way, we get the consequential collateral benefit of addressing the NTDs through what is already taking place or could be easily and mechanically expanded in an easy, practicable, community-based way at ground level up when dealing with HIV/AIDS, TB and malaria programmes. Building on that community health approach should in itself bring benefits to the NTDs. The NTDs themselves tend to be rather more specifically focused and are somewhat more geographically identified than some of those broader-range diseases. We need to be careful, therefore, not to force or to graft something on to them: I take the point seriously, and the answer is probably through synergies.

On 30 January this year, we had the London declaration, which took us a step further and set us the challenging 2020 deadline to demonstrate real progress. The meeting brought together some of the countries most heavily afflicted by NTDs—pharmaceutical companies, donors, academics, foundations and international financial institutions. Together we pledged to focus on 10 diseases, majoring on the five that preventive chemotherapy can control, such as schistosomiasis, and five that fall into the intensified disease management category, including guinea worm and visceral leishmaniasis, and to continue to support research. I hope my hon. Friend is pleased with this emphasis on research about which I am pretty obsessed. I had to give evidence myself yesterday to the Science and Technology Committee, which was not easy.

Jeremy Lefroy: I am delighted by the emphasis on research. As the Minister has already said in his speech, the UK is a world leader in research. I have visited the Liverpool School of Tropical Medicine and was mightily impressed by what I saw there. We have also had huge contributions from the London school and Imperial college among others. I am delighted to hear that the Government place such great emphasis on research.

Mr O’Brien: As ever, one should back centres of excellence. We are all pleased to acknowledge that. I was pleased to see that the director of the Liverpool School of Tropical Medicine was awarded a CBE in the recent Queen’s honours list. Essentially, the challenge is set for all of us to work together in a complementary fashion through an overall strategy that allows these diseases to be managed within a country’s primary healthcare system—to the extent that there is capacity in the system to work with—and ultimately to be eliminated as a public health problem. National legislatures have an important role to play here in making the case to Health and Finance Ministers on behalf of their constituents.

The session in London was groundbreaking, but after the fine words, the question is how to put them into effect. The first point is that of course we are building on a number of existing partnerships that for years had sought additional resources to expand their range and coverage. The second point, which is an answer to one of my hon. Friend’s questions, is the positive response. In many ways, it also addresses the point made by my hon. Friend the Member for Warwick and Leamington (Chris White) who helpfully reminded us that we must continue with commitment to build awareness among the public. There must be a public buy-in and sense of ownership of this approach. There is the political will within the UK to sustain the support for these tremendous interventions that have such an effect and impact on the most vulnerable in the world. Getting that positive response and support from organisations such as the Children’s Investment Fund Foundation and Geneva Global was encouraging.

In late 2011, a number of institutions here launched the UK Coalition against NTDs as a collaborative partnership between UK organisations actively engaged
in research, implementation and capacity building for NTD control at scale. Bringing considerable experience to bear on lymphatic filariasis, schistosomiasis, guinea worm and avoidable blindness are at the forefront of the push for integration, especially at the country level, with country and other developmental partners. Its aim is to expand the numbers of organisations and sectors committed to supporting NTD control.

What has happened over the past five months? The UK has agreed with WHO how to strengthen its NTD department capacity. That is important, as the department plays the key role of convening and setting standards, as well as helping ensure that the donated drug supply matches and meets demand. My Department has made considerable progress in developing the new trachoma and visceral leishmaniasis programmes, as well as programmes for an integrated approach to tackling neglected tropical diseases in two countries.

Expanding programmes to tackle neglected tropical diseases is an international effort. We are working closely with colleagues, particularly in the United States Agency for International Development, the World Bank, WHO and the Bill and Melinda Gates Foundation, to ensure that we continue to seek effective mechanisms for tackling such diseases while working through health systems, for example by exploring mass drug administration through schools and the role of improved water and sanitation.

Working collaboratively in-country is high on the agenda, as is developing strategies for working in challenging countries with heavy NTD prevalence, such as Nigeria, Democratic Republic of the Congo, which the Select Committee on International Development recently visited, and South Sudan, where I was recently. That will reinforce value for money and avoid duplication, which is vital to increasing impact.

Binding together all that work is our relentless focus on the achievement of results. Our bold decision to maintain development spend at 0.7% of gross national income at a time of UK spending austerity brings with it an obligation to demonstrate to our constituents as well as to those benefiting from our programmes that the money is being extremely well spent.

The results of our investment will be huge. By 2015, UK support will help protect more than 140 million people from neglected tropical diseases and the suffering, disability and death that they may cause. To do so, we have increased our financial investment and cumulative spend from £50 million to £245 million by 2015. Our investment provides a platform for expanding our work with the NTD community. With them, we can build on partnerships for change among international agencies, Governments, academic institutions, non-governmental organisations, corporations, national Ministries of Health, and most of all with people who live where the road ends. Increasing Government commitment through increased domestic resource provision is the starting point for sustainability, including strengthening the systems that deliver health services.

I pay tribute to a vast range of academics, campaigners, NGOs and parliamentarians. Within just two years of the formation of the coalition Government, we have made a massive step up. There is cross-party recognition of a commitment to scale up over the past couple of years. I am pleased to say in the context of our overall commitment to international development on behalf of the British people, whose broad generosity we are able to express through such innovative programmes.

We must recognise and accept that there is a risk of failure. Although we think that the interventions are well proven and their value for money will be great, as my hon. Friend the Member for Stafford said, there was a reverse on malaria in the past. I have just returned from the Sahel, where we were considering nutrition, a completely separate issue. Part of the challenge is that as we achieve success, the pictures will not be on our television screens. Being able to sustain it means committing continuing resources at the same if not greater levels. We must retain the political will to do the right thing through early interventions that work, making the political case all the tougher. Therefore, having champions such as my hon. Friend and the two colleagues who have joined him today is vital as part of the broad coalition of interest, which will ensure that we have the greatest impact in our generation for the most deliverable solutions for some of the greatest need in the world.

My hon. Friend the Member for Stafford asked about vaccine development, which he knows I support strongly, in many respects, for all diseases for which it is possible. We all wait with bated breath to hear whether the first vaccine for a parasite-borne disease, malaria, will become an effective element in the toolbox against that disease and for the control of its transmission. Our support for vaccine development, particularly for neglected tropical diseases, is given primarily through the drugs for neglected diseases initiative and through Tropical Diseases Research at the WHO. Working collaboratively through those institutions, we harness the greatest expertise. Of course, as with all vaccines, we need proof that it really works in adults and children effectively and efficaciously. It is rare to find a vaccine that is an absolute solution rather than just a tool in the box.
QUESTION FOR SHORT DEBATE: HOUSE OF LORDS 4TH JULY 2012

Baroness Hayman GBE, PC: My Lords, I, too, congratulate the noble Lord, Lord Fowler, on initiating this debate and on his long-term commitment in this area. I declare non-financial interests as a trustee of the Sabin Vaccine Institute and vice-chairman of the Parliamentary All-Party Group on Malaria and Neglected Tropical Diseases.

The noble Lord, Lord Fowler, said that these diseases tackled by the global fund do not form neat, separate boxes. Indeed, they do not. Tonight, I want to concentrate on the connectivity and co-morbidity between neglected tropical diseases and the diseases covered by the global fund. Recent evidence, published in the New England Journal of Medicine in an article by Peter Hotez the director of the Sabin Vaccine Institute, Jeffrey Sachs, and others has shown that there is a widespread geographical overlap between the prevalence and severity of HIV/AIDS, tuberculosis, malaria and NTDs. In the brief time tonight, I wish to highlight some of the opportunities that the cheap and effective treatments available for NTDs bring to that fight against HIV/AIDS, malaria and TB.

Investment in mass drug administration programmes were given a great boost at the London summit on NTDs, partly by, as the noble Lord, Lord Parekh, will be pleased to hear, the vastly increased donations of drugs from pharmaceutical companies and the very welcome additional funding from DfID. Sustained effort in this field would not only diminish the suffering and increase the educational and economic prospects of some of the world’s poorest people but, beyond that, additional resources and support from the global fund for integrated programmes could prove highly potent in the fight against the major killers that we are discussing tonight.

The scientific evidence for such an approach is, I believe, growing more potent by the day. For example, we know that those poor children infected by helminth-horrible worms which debilitate and stunt their lives and which can be treated for 50p per child per year are more likely to acquire TB, and the acquisition of TB will make for more expensive and problematic treatments. Similarly, when hookworm overlaps with malaria, as it does throughout sub-Saharan Africa, the result is profound and debilitating anaemia, especially in young children. The association between schistosomiasis and HIV prevalence and susceptibility is becoming clearer all the time. Research has shown that treating girls and women regularly for schistosomiasis can help to protect them from HIV infection, and that women with female urogenital schistosomiasis, which causes genital lesions, are three or four times more likely to have HIV infection.

It is difficult to deal with some of these complicated interactions in the short time available but I should like to make it clear tonight that, by investing in research into possible vaccines for some of these diseases, bundling together treatments for NTDs and the global fund diseases, we do not lose focus; rather, we prevent ourselves putting on blindfolds that could stop us getting great value for money and alleviating much suffering.