



UNITING TO COMBAT
NEGLECTED TROPICAL DISEASES

Reaching a Billion

Ending Neglected Tropical Diseases: A gateway to Universal Health Coverage

Fifth progress report on the London Declaration on NTDs



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Over the past 5 years, the scorecard has displayed an important snapshot of where we stand and where action is needed to achieve goals.

5th Scorecard on Progress

London Declaration NTDs		Coverage and impact milestones	Program support milestones	Drug requests filled	Research	Overall progress
Preventive chemotherapy (PC)	Lymphatic filariasis	2	2	1	1	2
	Onchocerciasis	2	2	1	2	2
	Schistosomiasis	3	2	1	3	3
	Soil-transmitted helminths	1	1	1	2	1
	Trachoma	2	2	1	2	2
Management (DM)	Chagas disease	2	2	1	3	2
	Guinea worm disease	2	2	1	3	2

What we can learn from 5 years of progress on neglected tropical diseases



Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

If we are serious about universal health coverage, we must intensify our efforts and our commitment to control, eliminate or eradicate these diseases by 2020.

The story of neglected tropical diseases (NTDs) is one of great progress and remaining challenges. Five years ago, the world committed itself to accelerating the control, elimination and eradication of 10 NTDs by 2020. Since then, tremendous success stories have emerged.

The World Health Organization (WHO) has recently validated 10 countries in which lymphatic filariasis is no longer a public health problem: Cambodia, the Cook Islands, the Maldives, the Marshall Islands, Niue, Sri Lanka, Thailand, Tonga and Vanuatu; Togo leads sub-Saharan Africa in achieving this milestone. Four countries – Colombia, Ecuador, Guatemala and Mexico – have been verified as ‘onchocerciasis-free’. Trachoma has been eliminated as a public health problem in Cambodia, the Lao People’s Democratic Republic, Mexico, Morocco and Oman. Human African trypanosomiasis (sleeping sickness) is on track for elimination as a public health problem and dracunculiasis (Guinea worm disease) is poised for eradication. These are only some of the tremendous accomplishments that we can celebrate.

Many factors underpin this success. Two elements are particularly relevant to continued progress, not only in defeating NTDs but also to achieving the United Nations Sustainable Development Goals (SDGs). From the beginning, the movement to end NTDs has been defined by partnerships and collaboration among a wide range of stakeholders – governments, donors, civil society, the private sector and academia. In this SDG era, such partnerships must be promoted and used as a model because the SDGs challenge us to work not only across sectors but also across stakeholder groups.

The second element is country and regional ownership. One of the main reasons for the important progress on NTDs is that countries have translated international targets into national goals and strategies, with the support of the international community. We have seen over the years that country ownership is essential if we are to deliver tangible results at scale.

Despite these successes, it is important to recognize that significant work remains. Still, millions of people around the world are debilitated by NTDs. If we are serious about universal health coverage, we must intensify our efforts and our commitment to control, eliminate or eradicate these diseases by 2020.

Partnerships and country ownership will continue to be critical, and efforts to address NTDs must be built into strengthened health systems and universal health coverage.

In that spirit, I would like to take this opportunity to thank Uniting to Combat NTDs for being a partner in the efforts of health ministries and other implementing partners and stakeholders to reach the poorest and most vulnerable people on our planet. The work of all stakeholders in supporting WHO is vital and has the potential to transform millions of lives.

I wish you a very happy fifth anniversary of the London Declaration on Neglected Tropical Diseases, and I look forward to our continued collaboration in achieving universal health coverage.

Executive summary: Beating 10 diseases, reaching a billion people

When the London Declaration on Neglected Tropical Diseases was signed in 2012 by a diverse group of partners, one sentiment was universal:

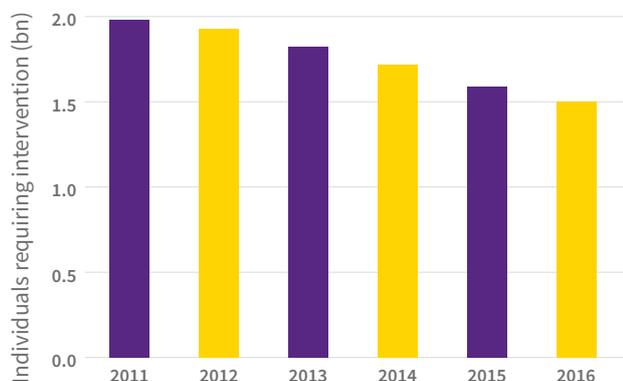
With a collaborative global effort, we can defeat these debilitating diseases of poverty and underdevelopment.

Five years later, this strong partnership has now reached over a billion people in a single year, making remarkable strides towards achieving the WHO goals for the control, elimination and eradication of 10 NTDs. During this key anniversary year, we celebrate the progress to date and rally forward towards 2020 and beyond.

1 billion people received treatment for at least one NTD in 2016

NTDs place a heavy burden on over 1.5 billion people on the planet. They are diseases of the poor and vulnerable and affect the most impoverished, marginalized, hardest-to-reach communities in both low- and middle-income countries. Their impact on individuals and on communities can be devastating. They reduce life expectancy and the educational and economic opportunities of affected individuals and of the communities they live in.

Numbers of people requiring interventions against NTDs



Global public-private partnerships are improving a billion lives

The London Declaration in 2012 was a historic milestone that enabled progress in treating and reducing the spread of NTDs. It demonstrated the impact of collaborative action between the public sector, the private sector, communities and nongovernmental organizations (NGOs).

Bill Gates, co-chair of the Bill & Melinda Gates Foundation and an endorser of the London Declaration, said at the fifth anniversary event:

‘Thanks to this partnership, these neglected diseases are now getting the attention they deserve so fewer people have to suffer from these treatable conditions. There have been many successes in the past 5 years, but the job is not done yet. We have set ambitious targets for 2020 that require the continued commitment of pharmaceutical companies, donor and recipient governments, and frontline health workers to ensure drugs are available and delivered to the hardest to reach people.’

Five years on, we have much to celebrate. The London Declaration has encouraged unprecedented global action and progress in the fight against NTDs. In 2016 alone, more than one billion people, in the world’s poorest countries were treated for at least one NTD. That’s one in seven of the world’s population who received treatment for an NTD.

98% reduction in Guinea worm cases, from 1,060 in 2011 to 26 cases in 2017

In 2011, just under 2 billion people (1.9 billion) required interventions against NTDs. This figure dropped to 1.5 billion in 2016, representing a decrease of over 400 million who no longer require preventive chemotherapy, mainly due to control of lymphatic filariasis (LF).

With the record-breaking drug donation programmes that are a cornerstone of the London Declaration partnership, countries are eliminating these diseases, thereby reducing the overall public health burden. The drug donation programme was recently recognized in the Guinness Book of Records as the largest of its kind in history, with the most medicines donated in a 24-hour period.

68% drop in sleeping sickness cases, from 6,747 in 2011 to 2,184 in 2016

NTD programmes are a gateway to universal health coverage

NTD programmes reach some of the world's poorest communities, and the creative strategies tailored for challenging, complex settings can provide a gateway to UHC. From the nomadic tribes in the deserts of Niger to the Yanomami tribe in the rainforests of Venezuela and the mountains of Brazil, NTD programmes are providing high-quality treatment and community-based care in remote rural areas never before reached by health systems, by training health workers and empowering health facilities with scant resources to reach more people more effectively. These programmes fuel ideas and blueprints for culturally relevant global health solutions.

The essence of UHC is ensuring that everyone has access to high-quality essential health care without suffering financial hardship. Population coverage is key to the UHC journey. NTD programmes can open access to populations that are some of the most challenging to reach.

10 countries have eliminated lymphatic filariasis as a public health problem



Progress, year after year

Some of the numbers that give us much reason to celebrate:



Human African trypanosomiasis

In 2016, only 2,184 cases of sleeping sickness were reported worldwide, down from 6,747 in 2011.



Trachoma

Five countries have been validated by WHO as having eliminated trachoma as a public health problem: Cambodia, Lao People's Democratic Republic, Mexico (2017), Morocco (2016) and Oman (2012).



Lymphatic filariasis

In 2017, four countries – the Marshall Islands, Thailand, Togo and Tonga – eliminated LF as a public health problem, bringing the total to ten countries (with Cambodia, the Cook Islands, Maldives, Niue, Sri Lanka and Vanuatu).



Guinea worm disease

Guinea worm disease, which 30 years ago afflicted more than 3 million people in 20 countries, is on the brink of eradication, with just 26 cases in two countries.



Onchocerciasis

Onchocerciasis has been eliminated in nearly all of the Americas. Colombia (2013), Ecuador (2014), Guatemala (2016) and Mexico (2015) have been validated as 'onchocerciasis-free'.

These gains were made possible by three factors:

1. Strong country programmes are reaching more people with NTD interventions than ever before.
2. Billions of treatments are donated by the pharmaceutical industry. Within the drug donation programmes, more than 1.8 billion treatments were donated to impoverished communities, reaching over a billion people in 2016 alone.
3. Government donors (led by UK aid and USAID) and private philanthropists are providing generous funding. US\$ 812 million were pledged by governments and private donors at the NTD Summit in Geneva in April 2017.

Progress is driven by the commitment of the governments of countries in which these diseases are endemic, NGOs and front-line health workers who ensure that donated drugs reach the people who need them.

Investments in innovation and technology have given us better tools to prevent, detect and treat NTDs.

- New research shows that new combinations of three existing drugs (ivermectin, diethylcarbamazine, and albendazole [IDA]) can dramatically improve treatment for LF and decrease the duration of programmes. This finding has been endorsed by WHO for use in programmes to accelerate progress towards elimination and is now supported by an extended ivermectin donation from Merck.
- Technology has dramatically enhanced mapping, improving our ability to target efforts where they are most needed and share with countries and partners for planning.
- Through public-private partnerships, R&D breakthroughs are being made that could dramatically shorten the path to end some NTDs. For example, new oral treatment for sleeping sickness that is effective in all stages of the disease simplifies diagnosis and treatment, allowing patients to receive treatment closer to where they live and work.

Join us on the journey to defeat NTDs

The vision of a future free of NTDs is built on our successes, applying the lessons learnt and continually seeking additional tools, strategies and partners to help continue progress and address further challenges. Our collective action and partnerships have proven that we can achieve outcomes that were only envisioned a few short years ago.

However, the path to NTD elimination and universal treatment remains steep. The barriers in reaching the underserved are still high and will require financial resources, political commitment, new tools and other innovations.

Financial resources are needed to ensure that donated medicines reach everyone everywhere. Although over a billion people received NTD treatment in 2016, 500 million people did not. More funding is needed to ensure that NTD programmes reach all the people and communities affected by these diseases. WHO estimates that an additional US\$ 300-400 million per year will be required through to 2020.

Political commitment in the form of strong leadership in affected countries is vital to sustaining progress against NTDs, particularly in the face of shifting economic climates and competing health priorities.

New tools and other innovations are the cornerstone of the NTD programme. Effective tools will move us faster and further along the path. Continuous innovation, development and adaptation will be required to ensure that no one is left behind.

Through the Uniting to Combat NTDs partnership, we have learnt from each other, in the service of and in partnership with the countries and the people affected by these diseases. The rewards of supporting a country's NTD programme, of heralding news of progress to elimination, can scarcely be described in the pages of a report. They can best be illustrated by the transformation of communities into places where fewer people are held back and barred from full participation in and the possibility of contributing to their country's development. We are geared towards a future in which we continue to grow and learn, welcome new partners, adapt programmes to new circumstances and embrace NTD prevention and disease management as part of universal health care.

We must continue to innovate in both programmes and tools. We now have a strong partnership. We share successes and set-backs, and together we will get the job done.



Uniting partners reaffirm their commitment to leave no one behind in the fight to end NTDs

In April 2017, partners from all over the world – endemic country governments, development funders, NGOs, academics and others – came together in an unprecedented gathering to unite around the common goal of ending the suffering caused by NTDs.

Reaffirming the commitments set out in the London Declaration, we commit to leave no one behind in the fight to end NTDs.

We will:

- support national efforts to beat NTDs
- embed NTDs in national systems and development priorities
- mobilize commitments and resources to elimination efforts
- collaborate across sectors
- work in a way that strengthens national health systems.

For the full declaration, see the Uniting to Combat NTDs website

Sita's story

Visceral leishmaniasis (VL) is a parasitic disease characterized by bouts of fever, weight loss, swelling of the spleen and liver and anaemia. If left untreated, it is almost always fatal.



Spread by the bite of an infected sandfly, VL (known as kala-azar in South Asia and East Africa) typically affects the poorest, most marginalized people, who often live in remote communities with limited access to health facilities.

The KalaCORE programme is an initiative to reduce the health and economic impact of VL. It is funded by UK aid. The programme supports governments in East Africa in controlling the disease and governments in South Asia in eliminating it.

Active case detection in areas with high case loads of VL is an essential component of the elimination strategy in India. In Bihar – chosen because of high case loads of VL in previous years, sessions were held with community members to raise their awareness of the disease and help them to understand the causes and how to prevent it.

Eight-year-old orphan Sita Kumari had had fever for over a month. She lived with her aunt and her brother, who worked as a labourer, making just enough money to meet the basic needs of the family. However, he was struggling to cover the cost of local doctors, who had treated her without success.

Sita and her remaining family are part of the *mallah* (boatman) caste, a marginalized group at the very bottom of the community social structure. Over 70% of VL patients in Bihar live in households below the poverty line. It is a disease of the poor.

Active case detection in areas with high case loads of VL is an essential component of the elimination strategy in India.

Sita's aunt told the session facilitator about her niece. The facilitator told the aunt about the free 1-day treatment available for VL patients in government hospitals. The aunt took Sita to Sadar Hospital, where she was treated with donated AmBisome®.

As part of the government initiative, VL patients and their caregivers are compensated for any loss of wages during the illness and for additional expenses such as transport, food and any other medical fees.

A few days later, Sita's brother received a cheque for RS 6,600, and he received a further RS 500 on completion of her treatment.

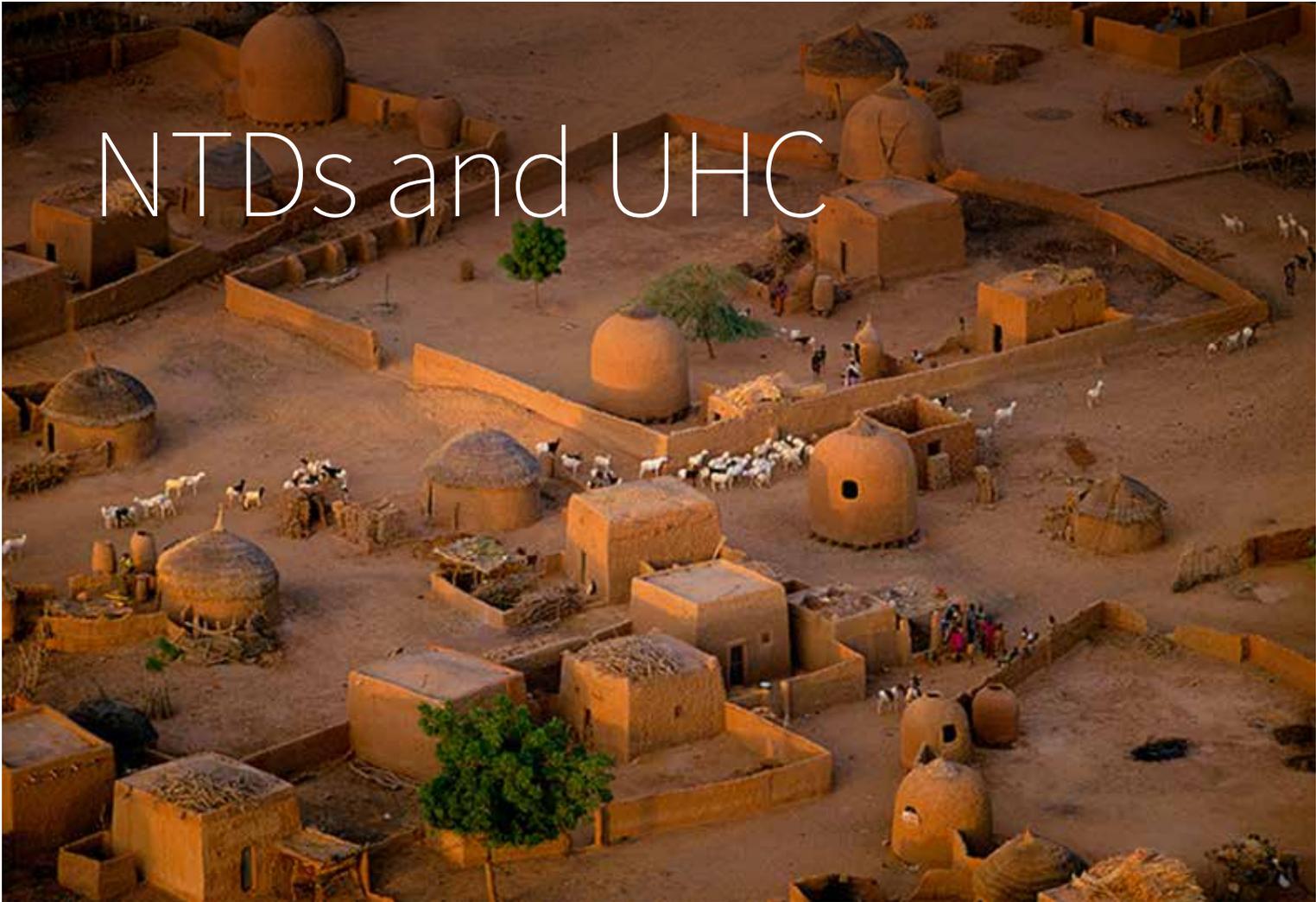
As part of the government initiative, VL patients and their caregivers are compensated for any loss of wages during the illness and for additional expenses.

Sita made a full recovery. She enjoys playing a local game called kit-kit with her friends and occasionally watches TV at her uncle's house. Her family are now aware of the symptoms of VL and encourage others in the village to seek treatment at government clinics.

Sita encountered a number of barriers to being cured, from an incorrect diagnosis to the financial burden, which prevented her from receiving the right treatment right away. Her story is not unique. In India, patients and families affected by the disease can become poorer due to the financial cost of the illness, which has been shown to exceed 14% of the total annual household expenditure. In Bihar alone, over 70% of VL patients lose income due to the disease, and almost 80% have had to borrow money to meet the cost of treatment.

In Bangladesh, Ethiopia, India, Nepal, South Sudan and Sudan – the countries that have the highest burden of the disease globally – the KalaCORE programme is supporting improved access to prompt diagnosis and effective treatment for VL. The programme trains health workers and ensures that health centres are equipped with the appropriate drugs and testing kits. Hard-to-reach communities are provided with information and education to encourage health-seeking behaviour. KalaCORE is also strengthening national surveillance systems and vector control for protection against the sandflies.

1. India VL patient baseline preliminary results, 2016, KalaCORE programme



NTDs and UHC

Ending neglected tropical diseases – a gateway to universal health coverage

NTDs affect more than 1.5 billion people in the most impoverished, marginalized, remote communities. Yet, in 2016 alone, more than 1 billion people were reached with treatment for at least one NTD. The scope and access of NTD programmes to some of the world's poorest communities can provide a gateway to universal health coverage (UHC).

The NTD delivery platform can support ministries of health in ensuring broader, equitable access to care and services. Training health workers to provide high-quality treatment, conducting novel disease surveillance, and encouraging referral to the local health facility help to strengthen health systems in countries.

Equity: NTD programmes reaching the unreached

In 2016 alone, interventions against NTDs were delivered in over 130 countries around the world. From the nomadic tribes in the deserts of Niger to the Yanomami tribe in the rainforests and mountains of northern Brazil and southern Venezuela, community health workers covered vast distances, on foot and by boat, by camel and by bicycle, to reach those who needed treatment.

Where there is poverty, NTDs are commonly an accepted part of life. But this is not inevitable. Togo, ranked 166 of 188 countries on the human development index, recently became the first sub-Saharan African country to eliminate LF. Similarly, Burkina Faso, which is ranked 185

Case study

Expanding the reach of services in Niger

Against all odds, community drug distributors in Niger are providing NTD treatment to populations at risk. Niger is a vast West African country in the Sahel, of which two thirds (1,267,000 km²) is mostly desert. Battling temperatures up to 45 °C, violent sandstorms, sudden drastic changes in weather, security risks and long distances on foot, community drug distributors are making a sacrifice for their communities and their country and are to be celebrated.

Villages are very far apart, especially in the northern part of the country. Even within the same village, homesteads may be up to 5 km apart. At times, the drug distributors travel distances of up to 170 km on sand and stone, making it difficult even by motorcycle.

The central zones are populated primarily by nomadic groups, who may change their location weekly or sometimes daily however, the drug distributors working in the NTD programme keep up with their movements in order to maintain high treatment coverage.

In spite of all the challenges, in 2016 alone, nearly 9 million people were treated for one or more NTD, with funding from the United States Agency for International Development (USAID).

of 188 countries, with nearly 12.5 million individuals at risk of five NTDs that can be treated by preventive chemotherapy (PC NTDs), achieved nearly 90% overall coverage in 2016.

Combating NTDs and reaching poor rural communities can put countries on the pathway to achieving UHC and, in turn, shared prosperity.

Population coverage: protecting the last billion

The average global target of up to 80% coverage for all NTD programmes by 2020 is aligned with the UHC target for quality essential services by 2030. As shown in Figure 1, NTD programmes are approaching that goal.

Before the London Declaration, in 2011, average coverage of PC NTDs was 37%. Thus, out of the 1.9 billion

people requiring treatment for at least one PC NTD in 2011, 1.2 billion were not treated. With a strong partnership, coverage had increased to 63% of those in need by 2016.

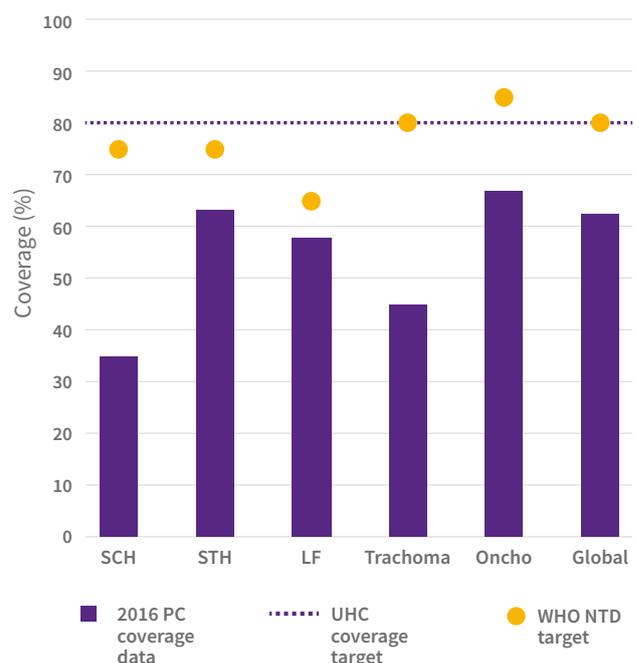
The NTD programme has now become one of the largest health programmes in the world, covering nearly every region at risk and protecting over 1 billion people worldwide.

As the NTD programme is community-based, ministries of health are not only ensuring coverage of marginalized populations but evidence shows that they are also reaching men and women equitably with treatment through mass drug administration (MDA).

In some settings, the NTD programme represents the first access of communities to preventive services. This is well documented for the Yanomami population, for whom the onchocerciasis elimination programme led to more comprehensive provision of primary health services.

Additionally, coverage is increasing for NTDs that require innovative and intensified diseases management and cannot be prevented through MDA. Diagnostic tools that can be used by community workers in remote areas to

Figure 1: Comparison of 2016 coverage for PC NTDs with the WHO NTD target and the UHC coverage target (over 1 billion people reached with PC in 2016)



Case study

Novel techniques in diagnosis increase the capacity of community health workers

In Ghana and Malawi, a trial was conducted to examine the use of mobile technology to record morbidity in patients with lymphoedema and hydrocoele simply and accurately. Both are chronic conditions caused by LF. Local community health workers were trained to recognize the conditions and to use SMS mobile devices to report cases.

The data were mapped to help the ministries of health establish the prevalence of the diseases in a given area, in order to provide services to those affected by prioritizing, planning and starting treatment and care programmes. In Malawi, about 1850 cases of hydrocoele and 650 cases of lymphoedema were identified. The Ministry of Health, with the support of the Liverpool School of Tropical Medicine and funding from UK aid, is now providing an essential minimum care package. Hydrocoele surgery camps and training in lymphoedema treatment at home were started within months of completion of mapping in the two most endemic districts.



prevention and services for people affected by NTDs through the primary health system. For example, through this training, in 2016, a record 260,000 operations for trichiasis were performed, primarily in Ethiopia, where the highest burden of trichiasis is recorded.

In many communities affected by NTDs, drug distributors may be the only health workers they see. These workers are often volunteers from the endemic communities being treated. Their local knowledge is invaluable in establishing and strengthening trust between community members and the health system. Their community access and trust can also encourage patient referral from these hard-to-reach communities to local health facilities, as seen during the outbreak of Ebola virus disease in Liberia and Sierra Leone, where community drug distributors were a critical part of the response to the crisis.

Frequently, drug distributors are called upon to extend their role in community health care by delivering items such as long-lasting insecticide-treated nets, family planning tools and vitamin A supplements. The potential of this group of workers has yet to be fully tapped and should be explored by endemic countries.

Financial protection: generous drug donation reduces out-of-pocket health expenditure

Through the London Declaration and the Uniting partnership, industry partners have committed medicines worth over US\$ 17 billion for the fight against NTDs from 2012 to 2020. In 2016 alone, over 2.9 billion tablets for over 1.8 billion treatments were provided to the world's poorest populations.

In large part due to these donations, NTD interventions have been described as one of the most cost-effective in public health. In addition, they allow NTD programmes to give endemic communities access to health services without out-of-pocket payment, which is a known barrier to accessing health care, thus reducing the risk of catastrophic financial loss.

Even with free treatment, indirect costs such as transport, food and accommodation must be considered when discussing the cost of health care. The delivery platforms used in NTD programmes, which are embedded in the community, ensure that these costs are minimized for affected individuals.

diagnose NTDs quickly and effectively are key to this progress. Deploying these tools, the numbers of cases have fallen substantially. For example, the numbers of cases of human African trypanosomiasis (HAT) and VL were reduced by 68% and 60% respectively, from 6,747 and 53,727 in 2011 to 2,184 and 21,646 cases in 2016. Again, through the NTD platform, ministries of health are extending their capacity to diagnose and to treat impacted communities beyond their health facility walls.

As we move closer to global targets, strong national health systems will be critical to ensure that progress towards NTD control and elimination not only accelerates but is sustainable – recognizing that these targets can be met only with health systems that can successfully prevent, detect and treat NTDs.

Primary health care: an army of community health workers powering the NTD programme

The scale of the NTD programme is incredible. Through this platform, millions of health workers have been trained, from community drug distributors to nurses, surgeons and ministry of health programme staff. USAID alone trained over 1 million health workers in 2016, 900,000 of whom were drug distributors. Training strengthens health systems so that they can provide



Case study

Bringing treatment closer to home

Human African trypanosomiasis (HAT) must be quickly diagnosed by specialized, skilled staff in health facilities so that this fatal disease can be treated. The distance a patient must travel impacts whether or not they are able to get to treatment.

Throughout affected areas of Africa, new tools have allowed diagnosis in rural communities with poor access to electricity, allowing patients who previously had to travel an average of 25 km to access services nearer to their homes.

Over 80% have to travel over 3 hours to a treatment centre and 92% over 5 hours. By 2014, there were a 1,000 operating treatment centres in 23 endemic countries.

Return on investment: NTD programmes a best buy in global health

The end of NTDs offers a net benefit to affected individuals of about US\$ 25 for every dollar invested by funders.

The effects of meeting the WHO 2020 targets and the end of NTDs by 2030 have been calculated for nine NTDs.¹ Between 2011 and 2030, 600 million disability-adjusted life-years (DALYs) would be averted, corresponding to an average of 30 million DALYs per year. The health gains would include averting about 150 million manifestations of irreversible disease (such as blindness) and 5 million deaths. For PC NTDs, 96% of the health gains would be averting disability, and for the NTDs that require innovative and intensified disease management, 95% of the impact would be due to averted deaths.

According to the World Bank,² the estimated benefit in averted out-of-pocket health expenditure and lost productivity for affected individuals would exceed US\$ 342 billion during the period 2011–2030. The end of NTDs would offer a net benefit to affected individuals of about US\$ 25 for every dollar invested by funders, and

elimination could offer a 31% annualized compound rate of return overall: a fair, efficient investment in UHC and social protection for the poorest.

The cost of the NTD programme is a much smaller investment than that required for many other health initiatives. A paper published recently in *The Lancet*³ estimated that an additional US\$ 274 billion would be needed per year by 2030 to make progress towards the SDG 3 targets. The WHO estimates the costs of health sector interventions to end most NTDs to be US\$ 750 million per year until 2020 and US\$ 300 million per year from 2020 to 2030. Additional resources for environmental interventions, including water, sanitation and hygiene (WASH), vector control and veterinary public health, are also critical for the sustained elimination of multiple NTDs and UHC. Even so, NTD elimination efforts represent a fraction of the resources required to achieve the SDGs and yield a high rate of return.

The unequalled reach of NTD programmes can provide a gateway to UHC, with over one billion people treated in a single year, millions of health workers and community volunteers trained and services provided to people who are frequently far from a health facility. Eliminating the burden of NTDs could give individuals the chance to no longer be at risk for infection and be free to lead productive and fulfilling lives and can strengthen economies. The programme is implementable, the investment is achievable, and ending these diseases of poverty is within reach.

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2. Holmes KK, Bertozzi S, Bloom BR, Jha P. *Disease Control Priorities*, third edition. Vol 6. Major infectious diseases. Washington DC: World Bank; 2017.

3. Stenberg K, Hanssen O, Tan-Torres Edejer T, Bertram M, Brindley C, Meshreky A et al. Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *Lancet Global Health*. 2017;5:e875–87.



Case study

Domestic resource mobilization in Burkina Faso

Burkina Faso provides a good example of the power of domestic support. In a 10-year period (2004–2014), Burkina Faso’s government provided US\$ 300,000–400,000 per year to support their NTD programme costs. In 2016, the programme was assisted with a World Bank loan, to cover per diems and other expenses for community mobilization, monitoring and evaluation. Today, Burkina Faso, with the support of USAID and UK aid, has achieved nearly 90% coverage of its population at risk with MDA.

UHC principle	Description	The NTD programme
Equity	Everyone has access to quality essential health care regardless of geographical location, sex, ethnicity or economic or social status.	NTDs affect 1.5 billion of the poorest, most marginalized people, living in the most remote areas. In 2016, over one billion people were reached with treatment for at least one NTD. NTD programmes reach populations in the hardest to reach geographical settings; at the end of the road, track or river. Where people live, NTD programmes reach. In addition to ensuring coverage of marginalized populations, community programmes reach both men and women equitably through MDA.
Population coverage	WHO and the World Bank have agreed on a UHC target of at least 80% population coverage with quality essential health services by 2030.	The NTD programme has a global population coverage target of 80%, which is aligned with that of UHC. In 2016, over one billion people – one in seven of the world’s population – were treated for NTDs. This accounted for 63% of the population in need, closing in on the 80% target.
Primary health care	The cornerstone of health system strengthening is primary health care, the interface between health systems and people.	The NTD programme has trained millions of health workers throughout the health spectrum. In 2016 alone, USAID trained over one million health workers, including community drug distributors, surgeons, nurses and government health officials. This helped in 2016 to achieve a record-breaking number of operations for trichiasis, the leading infectious cause of blindness.
Financial protection	Countries should strive for 100% financial protection from both catastrophic and impoverishing health payments, helping to reduce out-of-pocket payment.	Generous drug donations from pharmaceutical companies and investments from donors to NTD programmes give poor people access to treatment without the risk of catastrophic financial loss. Through the London Declaration on NTDs, industry partners have committed to donate drugs worth over US\$ 17 billion to NTDs (2012–2020) and donors, to funding NTD programmes. In 2016 alone, donors invested close to US\$ 300 million that helped deliver over 1.8 billion donated treatments to the world’s poorest populations.

Community volunteers at the heart of combating blinding trachoma in Darfur

by Simon Bush and Adam Elkhair

'I remember Darfur as being one of the most beautiful areas of Sudan. The Mara Mountain was a well-known tourist destination, with the people being warm and welcoming.'

Adam Elkhair, Sightsavers



2 million

people were treated to prevent trachoma

Recruiting community volunteers

The first phase was finding community health volunteers to distribute the drugs. After years of not having proper health care, people were keen to receive training and be part of a team of volunteers helping to eliminate this disease in their communities.

The community volunteers were trained not only to distribute the drugs but also to support those with concerns about taking the drugs and to teach the community about the causes of trachoma, how to prevent it and how to seek treatment.

Going house to house to prevent trachoma

The MDA campaign was carried out house to house across Darfur to ensure coverage. The role of community volunteers was essential to the success of this campaign.

This programme in Darfur is a success story. Not just because of the huge number of drugs administered for the first time ever or for the large number of volunteers and health workers trained. It is also because many mothers are now aware of how to prevent trachoma and how to seek treatment. This is helping Sudan move closer to its trachoma elimination target and improving the lives of its citizens.

90%

of community health volunteers are women

Since the start of the conflict in Darfur, thousands of people have been forced to abandon their farms, homes, livestock and property. Livelihoods have been lost, and the way of life, which had existed for generations, was disrupted.

As displaced people moved across the country or made their way to the camps set up by humanitarian organizations, delivering any assistance to affected communities became increasingly challenging.

Many people were infected with trachoma. We suspected the numbers to be high and the area to be endemic. But in order to tackle the problem we needed to know where those affected people lived.

Being able to map trachoma meant that when the security situation began to improve, we could step in. With funding from the END Fund and improved security, Sightsavers was able to start the region's first MDA campaign to treat blinding trachoma in Central, West and North Darfur states.

'We have learnt about the importance of face cleaning and environmental sanitation and other useful hygiene tips.'

Asha Ahmed

Community member from Abu Zereiga village

The progress we have achieved to date would not have been possible without the intricate public-private partnership that fuels the global effort to eliminate NTDs. This partnership includes coordination with non-governmental organizations, industry, donors, academic institutions, endemic country governments and especially front-line health workers who help ensure that donated treatments reach the people who need them most.



A public-private partnership like no other

The partnership that fuels the global effort to eliminate NTDs





We achieved the Guinness World Record for most medication donated in 24 hours.

Record-breaking commitment of the pharmaceutical industry

Five years ago, the pharmaceutical industry joined the global health community in committing itself to supporting the ambitious goal of eliminating or controlling 10 neglected tropical diseases (NTDs) by 2020. This commitment, known as the London Declaration, has resulted in unprecedented global action and progress in the fight against NTDs.

2017 marks the five-year anniversary of the London Declaration. This milestone is an opportunity to pause and reflect on the result of efforts to control and eliminate these diseases – what has worked and what hasn't and what more needs to be done to achieve the vision of a world without NTDs.

Progress since 2012

The pharmaceutical industry has made substantial progress over the past 5 years in living up to the commitments of the London Declaration. In 2016 alone, the industry donated 1.8 billion treatments for NTDs, up from 970 million treatments in 2011. Thus, in 2016, over a billion people received treatment for at least one NTD. Additionally, breakthroughs in new tools, including innovations in disease mapping, have accelerated progress against NTDs by improving targeting of drug delivery and making treatment programmes more effective. As a result, five countries have been validated by WHO as having eliminated trachoma as a public health problem:

1.8 billion treatments donated by the pharmaceutical industry in 2016 alone

Cambodia, the Lao People's Democratic Republic, Mexico (2017), Morocco (2016) and Oman (2012). In 2017, four additional countries – the Marshall Islands, Thailand, Togo and Tonga – eliminated LF as a public health problem, bringing the total to ten countries (with Cambodia, the Cook Islands, Maldives, Niue, Sri Lanka and Vanuatu). Onchocerciasis has been eliminated in nearly all of the Americas, with Colombia (2013), Ecuador (2014), Guatemala (2016) and Mexico (2015) recently having been declared 'onchocerciasis-free'.

To mark the fifth anniversary of the London Declaration earlier this year, all the original signatories reaffirmed their pledges to do their part in combating NTDs and encouraged others to do the same.

Power of partnership

The progress that has been achieved would not have been possible without the intricate public-private partnerships that fuel the global effort to eliminate NTDs.

These partnerships include coordination with NGOs, the governments of countries in which these diseases are endemic and, importantly, the front-line health workers who help ensure that donated treatments reach the people who need them most.

This unprecedented global partnership has been recognized in the Guinness Book of Records for the most medication donated within 24 hours.

Reaffirming our commitment

The original signatories to the London Declaration remain steadfast in their commitment to eliminate NTDs and to contribute to SDG 3: Ensure healthy lives and promote well-being for all at all ages. On the occasion of the fifth anniversary of the London Declaration, we promise to:

Reaffirm our commitment to ending NTDs

- We reaffirm our respective pledges under the London Declaration on NTDs, including our commitments for drug donation and improved diagnostics.
- We pledge to explore new, innovative ways to accelerate global progress against NTDs, ensuring that our activities are sustained and sustainable, have a real impact and are increasingly owned and directed by the countries on the front line of the fight against NTDs.

Collaborate to develop and deliver life-saving interventions

- We will accelerate R&D, including through innovative

public-private mechanisms, to identify the new drugs, vaccines and diagnostics necessary to ensure long-term control and elimination of NTDs.

- We will play our part, in close collaboration with the governments of endemic countries, to strengthen the supply chain, from the first to the last mile. We encourage the global development community to work with the governments of endemic countries to ensure that adequate resources are allocated for full use industry donations.

Advocate for awareness, resources and improved health systems

- We will use our voices to raise awareness about the resources needed to remove the two primary risk factors for NTDs – poverty and exposure to disease. Ensuring access to clean water and basic sanitation, improving living conditions, ensuring vector control, health and education and strengthening health systems in endemic areas are all essential for NTD elimination.

A breakthrough in LF elimination: Merck announces an expanded donation in support of new treatment!



A new treatment, co-administering ivermectin, DEC, and albendazole (IDA), has shown to be superior to standard two drug approaches. This finding was so striking that an expert group convened and developed a pathway to rapidly evaluate the safety of this approach in MDA programmes for LF. Now over 10,000 people across 4 countries have been treated, demonstrating safety. After thorough review, WHO recommends IDA to accelerate LF elimination. In response, Merck announced

an expansion of the MECTIZAN® Donation Program (MDP) to reach up to an additional 100 million people per year through 2025. IDA use should be targeted to achieve LF elimination with high coverage and compliance, strengthening monitoring and evaluation to demonstrate impact. Countries eligible for the donation (currently using DEC and albendazole) could decrease MDA rounds and achieve elimination more rapidly releasing communities from risk, and resources, both human and financial, to target additional health and development challenges.

‘LF is on the short list of diseases that are targeted for elimination in the World Health Organization’s Roadmap on Neglected Tropical Diseases,’ said Kenneth C. Frazier, chairman and chief executive officer, Merck. ‘With the evidence put forward in the WHO’s new guidelines, we’re expanding the MECTIZAN® Donation Program to bring improved health and hope to millions of people as we work toward the day when LF is no longer a threat.’

New and diversified donors and partnerships supporting NTD programmes

The number of new donors that have joined to support NTD programmes in recent years is encouraging. It proves that evidence of impact is a tremendous motivation for investors. But, additional funding partners are still needed, as hundreds of millions of people still require treatment.

Being a donor is an opportunity to be part of a global partnership to remove NTDs as a barrier to prosperity. One estimate suggests that, if WHO's 2020 goals are met, nearly US\$ 52 billion in productivity could be saved in sub-Saharan Africa over the coming 10 years.

With the signing of the London Declaration in 2012 came a commitment by bilateral donor governments, private philanthropists, NGOs and pharmaceutical companies to control, eliminate or eradicate 10 NTDs by 2020. Although some of these groups had been funding NTD programmes for years, the London Declaration gave them renewed energy and a commitment to accelerate progress. Over the past 5 years, demonstrated outcomes of investment in national programmes have been a catalyst for new, diverse donors to join the fight against NTDs. In 2012, 22 endemic countries were identified as recipients of international support.¹ As of 2016, that number had doubled, with 45 endemic countries benefitting from the translation of donor support into strategies and progress against NTDs.

Government donors such as UK aid, the U.S. government's Agency for International Development (USAID) and private philanthropic donors such as the Bill & Melinda Gates Foundation have been at the forefront of NTD control and elimination efforts, continuing to allocate significant funds each year. Donors have invested nearly US\$ 300 million per year towards implementation costs, delivering over 1.8 billion treatments in 2016. USAID, for example, has provided US\$ 100 million per year over the past 4 years to national programmes in Africa, Asia, Latin America and the Caribbean. Over a ten year period investing in NTDs, USAID helped reach 935 million people with two billion NTD treatments.

US\$ 100 million per year provided by USAID in Africa, Asia, Latin America and the Caribbean over the past 4 years



US\$ 812 million pledged in April 2017 by donors over the next 5–7 years to end NTDs

To help link with new donors, the END Fund was established in 2012 as a platform to engage private philanthropists in investing in NTDs. Since its founding through 2017, the END Fund has mobilized over US\$ 100 million.

Among the partners that have joined efforts to fight NTDs through the END Fund are the Campbell Family Foundation, the Leona M. and Harry B. Helmsley Charitable Trust, the Shefa Fund, Al Ansari Exchange and the ELMA Foundation.

A growing number of individuals, foundations and corporations are investing in ending NTDs, joining organizations already supporting NTDs, like the Children's Investment Fund Foundation, the Conrad N. Hilton Foundation, the Carlos Slim Foundation, the Kuwait Fund for Arab Economic Development, the Queen Elizabeth Diamond Jubilee Trust and Mundo Sano.

Investing in NTDs is cost-effective. The NTD programme is the largest public-private partnership at USAID, leveraging US\$ 26 worth of donated drugs for every US tax dollar

1. The Children's Investments Fund Foundation, the Conrad Hilton Foundation, the END Fund, the Queen Elizabeth Diamond Jubilee Trust, UK aid Direct and USAID



US\$ 26 in donated medicines is leveraged for every US\$ 1 spent by USAID on NTDs

invested. The programme collaborates with national programmes to forecast demand and distribute the donated medicines to communities in need.

In April 2017, at the global partners meeting on NTDs, philanthropists, donors, governments, representatives of the pharmaceutical industry and other stakeholders pledged US\$ 812 million over the next 5–7 years to tackle NTDs. Leading this new set of commitments was UK aid, which committed £350 million over 5 years (equivalent to US\$ 450 million at the time of the announcement¹) to support NTD control and elimination around the world. The Government of Belgium, a new partner in NTDs, committed US\$ 27 million dedicated to the elimination of sleeping sickness in the Democratic Republic of the Congo. To further the effort, Vestergaard pledged to donate 20% of its insecticide-treated ‘tiny targets’, used to control the tsetse flies that transmit

sleeping sickness, scaling up to 100% over the next 3 years as elimination nears.

To support innovation for impact, the Bill & Melinda Gates Foundation committed US\$ 335 million in grants over the next 4 years to support drug and diagnostic development and delivery, vector control, and operations research to optimize NTD programme implementation including US \$42 million to support eradication of Guinea worm disease.

US\$ **450 million** contributed by UK aid to the control of NTDs over the next 5 years

1. Based on an exchange rate of \$1.25 as at April 18 2017 (HMRC rates)

As the fight against NTDs continues, the global partnership should celebrate national and regional successes as they are achieved, while building momentum towards global success. The global NTDs effort could benefit significantly from increased domestic resource mobilization in the countries that bear the heaviest burden of these diseases. Not only would this be an internal investment in the fight against NTDs, it would also be an investment in country ownership and UHC. Collectively, by addressing NTDs, national governments, private and bilateral donors could transform the socio-economic prospects of the affected communities and countries worldwide by improving the health and productivity of current and future workforces.



Gulf States intensify the fight against NTDs

During the past 5 years, the leadership of donors in the Middle East and the Gulf States has continued to grow.



In November 2017, Sheikh Mohamed bin Zayed Al Nahyan, Crown Prince of Abu Dhabi and Deputy Supreme Commander of the Armed Forces of the United Arab Emirates (UAE), joined with global health partners to launch an innovative US\$ 100 million fund to support the elimination of two NTDs, river blindness and LF, in countries in Africa and the Middle East in which these diseases are a priority. This investment continues the commitment of the Emirates to disease elimination, which dates back to their early investment in fighting Guinea worm disease in the 1990s.

The support of the UAE builds on the long-standing commitment by the Kuwait Fund for Arab Economic Development (Kuwait Fund) which has been funding the fight against river blindness since the 1970s. In October



2017, the Kuwait Fund, donated an additional US\$ 4 million to the Expanded Special Project for the Elimination of NTDs (ESPEN), a project of the WHO's Africa Region.

The region's impact in combating NTDs is also due to private philanthropic donations. Donors in the Middle East region, including the Legatum Foundation, Dubai Cares, the Shefa Fund and Al Ansari Exchange, have contributed over US\$ 24 million through the END Fund for NTD projects throughout the world, including MDA for integrated NTD treatment, school-based deworming, WASH programming at schools and training of community health workers.

The NTD community is grateful to all those in the Middle East who have joined the fight against NTDs, both before and since the London Declaration, and looks forward to the collaboration of others to end these diseases of poverty.

Tackling stigma and poverty for people affected by leprosy in Nepal

Leprosy still affects some of Nepal's poorest communities. It perpetuates poverty and disability, and stigmatizes people with leprosy. This stigma prevents people – especially women – from participating socially in their communities.

To overcome this stigma, the RECLAIM project trained affected men and women to run local self-care groups. The groups encourage people to seek treatment and provide support to others affected by this commonly misunderstood disease. These self-care groups evolve into self-help groups, offering literacy classes and providing services to their communities. Members see better social inclusion and reduced stigma.



Patili Maya and members of the Ranichuri self-help group

For Patili Maya – a member of the Ranichuri self-help group – her journey has been remarkable. Her group repaired a road to give village children easier access to the local government school – the same road she was once forbidden to use because of her status as a person affected by leprosy.

Kishori Yadhav was terrified when he found out he had leprosy. Members of his village in Dhanusha district still believed in the myths surrounding the disease and he feared being banished from his home. Even his wife kept her distance, saying hurtful things to him.

After treatment, the Lalgadh Leprosy Service Centre taught Kishori and his wife about leprosy and the challenges that people affected face. He joined a self-care training course hosted by the centre and took the new skills he acquired back to his village. He now leads a self-help group that has organised basic literacy training for Dalit or 'Untouchable' women. The group also provided low-interest loans for

group members from their monthly savings scheme. Kishori now enjoys respect from his community and most importantly, his wife.

The RECLAIM project, implemented by the Nepal Leprosy Trust with support from American Leprosy Missions, tracked the impact group membership had on poverty.

The project demonstrated that self-care group membership can lead to improved social inclusion and more productive living.

Assessment of 50 groups comprising almost 900 people revealed that most members voluntarily became involved in community development activities. After 3 years, the study found that many had significantly improved their financial situation.



Kishori Yadhav leading a self-help group in Dhanusha district

Kishori Yadhav was terrified when he found out he had leprosy. His small village in Dhanusha district still believed in the myths surrounding the disease and he feared being banished from his home.

Reaching the unreached: the critical role of NGOs in beating NTDs

Non-governmental organizations (NGOs) are uniquely placed to reach the world's least-served populations and therefore play a critical role in working with governments towards achieving universal health coverage (UHC).



As trusted partners, NGOs have supported global and national NTD programmes in unique, often catalysing ways: ensuring national ownership of programmes, building technical capacity, undertaking research to provide the evidence for effective, scalable programme delivery and, most importantly in terms of achieving the SDGs, connecting some of the hardest-to-reach communities with formal health systems.

The NTD NGO Network (NNN), representing nearly 80 organizations, is a partner of national programmes in 100 NTD-endemic countries and manages more than US\$ 500 million in investments for a world free of NTDs. It provides a global forum for NGOs that are contributing to

the control, elimination and management of these diseases according to the internationally agreed WHO NTD roadmap.

The NTD NGO Network represents nearly 80 organizations, is a partner of national programmes in more than 100 countries and invests more than US\$ 500 million in grant funding and private investments to fight NTDs.



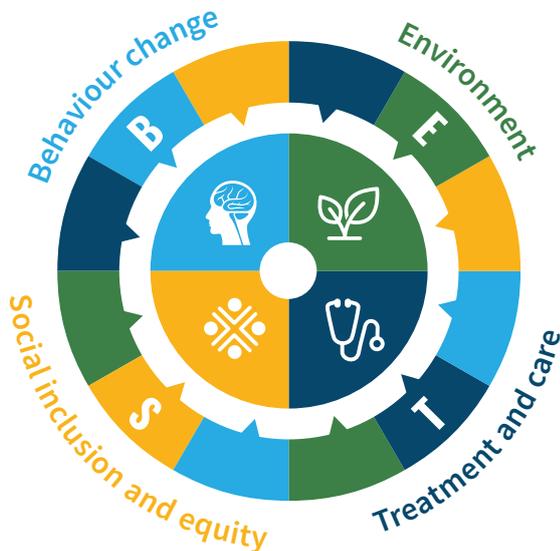


The BEST framework: a new platform for action and engagement

The momentum of the SDGs has driven further evolution of how the NTD sector thinks, talks and gets down to business. The BEST framework, launched by the NNN in 2016 as a platform for action and engagement, was developed to support the SDG goals of reaching the hardest to reach and ensuring that no one is left behind.

Developed with widespread consultation, the BEST framework provides a platform for accountability and cross-sectoral action by the NTD community in respect of behaviour, the environment, social inclusion, equity, treatment and care to drive progress in achieving national and global NTD targets.

BEST recognizes that action to combat NTDs is situated within the wider context of the environment and the economic and social dimensions of sustainable development. It unites the diverse cross-sectoral



efforts required to attain the targets for the control and elimination of NTDs. It sets out the NTD community’s commitment to forge new partnerships and collaboration among sectors to enhance the impact of the unparalleled scaling-up of donated medicines, to strengthen systems and services for the hardest-to-reach communities and to realize the long-term impact of investments in therapeutic coverage.

Within the BEST framework, members of the Network plan to establish new working groups to complement existing collaborations for water, sanitation and hygiene (WASH) and disability management; they will focus on integrated vector control and skin-related NTDs.

Many endemic countries have realigned their national development plans to the SDGs. Because of their clear links to ending marginalization and underdevelopment, advances in controlling NTDs have been recognized as potential tracer indicators of progress in equity, UHC and other areas, such as WASH. These provide opportunities to engage in and advocate for better policy frameworks for tackling NTDs and for greater domestic and international investment. The BEST framework provides a platform for engagement and embeds NTD elimination in national development and progress towards UHC.

B Changing behaviour is critical for reducing the risk of exposure to NTDs and for promoting health-seeking behaviour. It includes changing attitudes and behaviour at both institutional and individual levels to improve inclusion, access to services and collaboration among cross-sectoral NTD partners.

E The BEST framework embeds environmental measures for disease control in the NTD response to facilitate collaboration with stakeholders in programmes for WASH, veterinary public health and vector management.

S Social inclusion and equity can be ensured only by addressing the barriers. Health, WASH and other services must be inclusive and accessible, and communities must be empowered to participate and make decisions about their health.

T Achieving universal health coverage is critical to providing safe, effective, good-quality, affordable, essential treatment and care in the continuum of care for NTDs. This approach includes preventive chemotherapy, surgery, disease management, self-care and access to rehabilitation services.



From innovation to implementation: Successes in research since the London Declaration

Advances and innovations in research empower national programmes in the fight against NTDs, making it possible to treat more people faster. Since the signing of the London Declaration in 2012, multinational collaboration has led to advances in the delivery and monitoring of treatment and has streamlined programmes so that they can detect multiple diseases at once.

These innovations drive countries ever closer to the goal of eliminating NTDs.

NTD programmes are nested in ministries of health, so that maximizing their resources is a gain for countries. One innovation, the confirmatory mapping tool for lymphatic filariasis (LF), has already saved money for programmes, as it gives a clearer picture of LF infection than previous methods, which yielded uncertain results. Confirmatory mapping can prevent needless mass drug administration (MDA). For example, in Ethiopia and the United Republic of Tanzania, the tool saved the national programmes an estimated US\$ 9 million by establishing that MDA was not required in 52 districts.

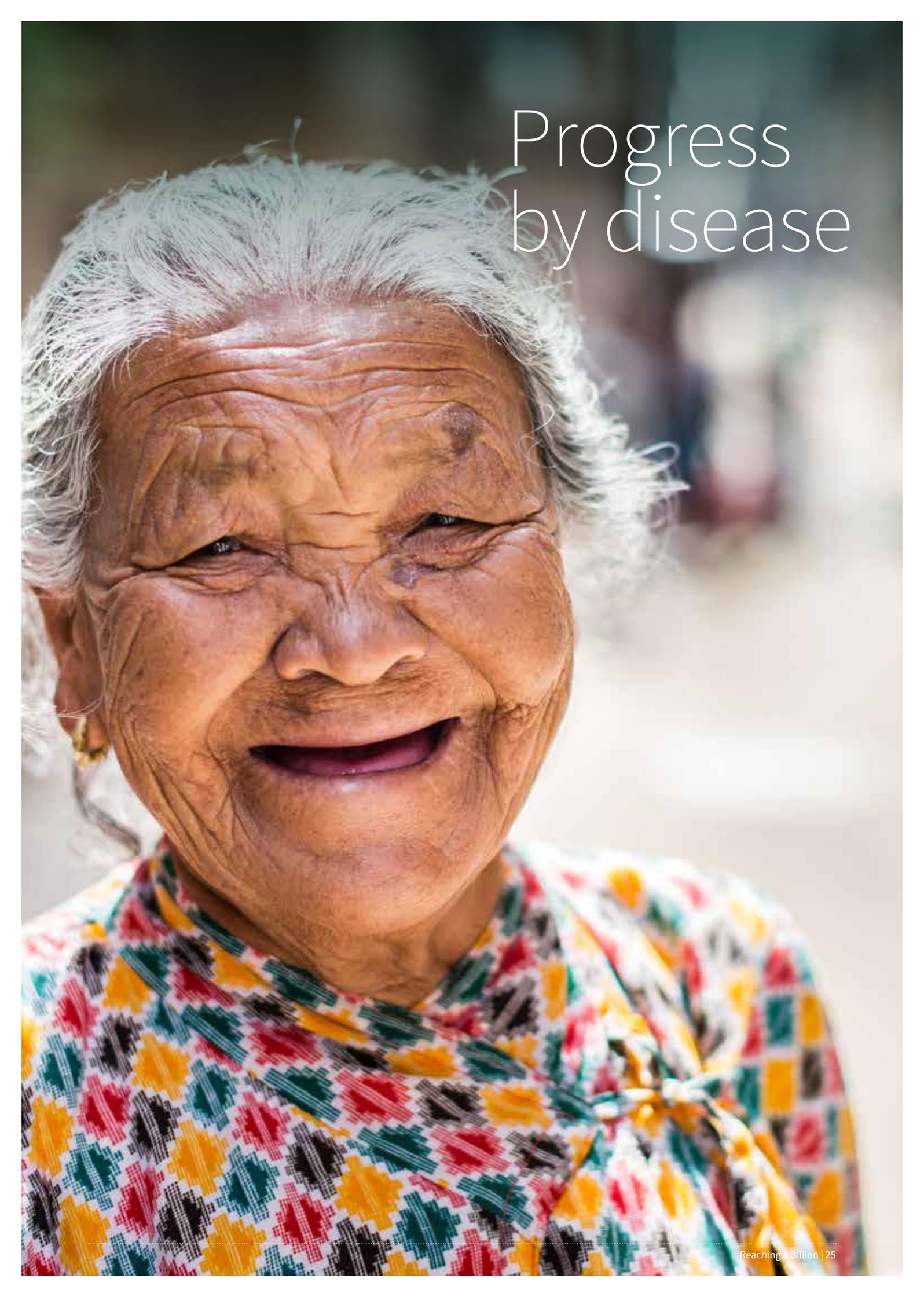
Research has also addressed challenges to MDA. Programme staff must know who has received NTD treatment and whether enough people have been reached. Unless they achieve high coverage, they might have to repeat MDA. The supervisor's coverage tool was designed to help programme managers assess the coverage of MDA while it is being implemented.

It was effective in identifying treatment gaps in Ethiopia and Nigeria, improving the coverage of the programmes.

NTD programmes do not operate in a vacuum, and stopping treatment for one disease may have an effect on another. This is the case for soil-transmitted helminthiasis (STH), which responds to the drugs for LF. Thus, as LF programmes are scaled down, STH infections could become more prevalent again. In 2015, the World Health Organization (WHO) published guidelines to help programme staff understand how LF treatment affects STH. By following the guidance, programme staff can determine whether MDA should be continued to control intestinal worms. This integrated approach has been extended to malaria, LF and STH in Haiti.¹

These and other innovations address key barriers between NTD programmes and disease elimination goals. Each tool has been influenced by the programmes in which they are used and endorsed by WHO. Their success proves the power of innovation in the fight against NTDs.

1. Knipes AK, Lemoine JF, Monestime F, Fayette CR, Direny AN, Desir L et al. Partnering for impact: integrated transmission assessment surveys for lymphatic filariasis, soil transmitted helminths and malaria in Haiti. *PLoS Negl Trop Dis.* 2017;11: e0005387.



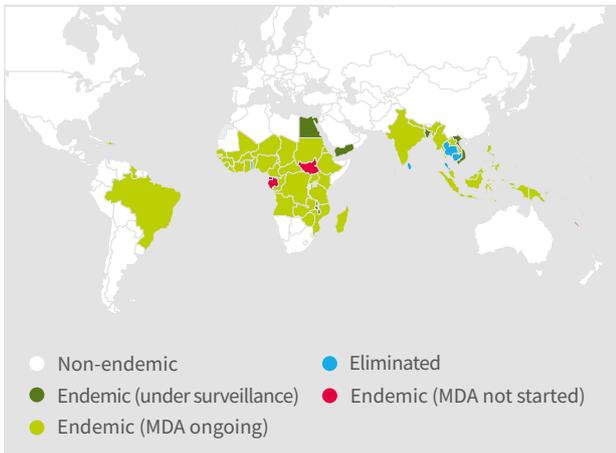
Progress by disease



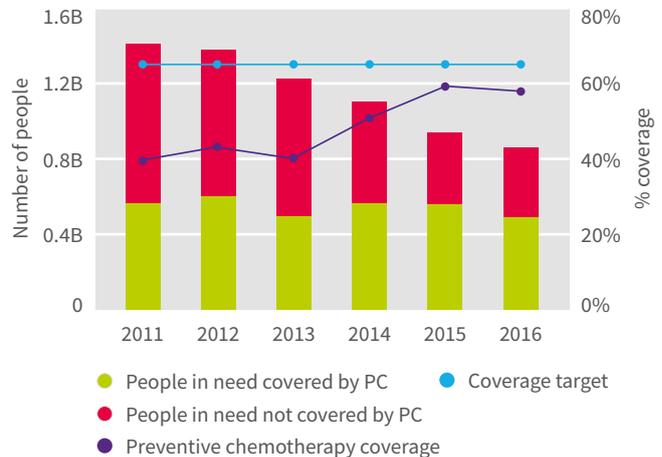
Lymphatic filariasis (LF)

LF is a mosquito-transmitted disease caused by parasitic worms that damage the human lymph system.

LF endemicity status (2016)



Preventive chemotherapy coverage



WHO roadmap target:

Global elimination as a public health problem by 2020

LF programmes globally have had a significant impact. 20 countries and 499 million people were no longer in need of MDA as of 2016, and ten countries have now eliminated LF as a public health problem. 92% of evaluation units assessed reached the threshold and no longer need treatment.

499 million

people no longer require MDA

Progress has continued, with treatment scaling up and coverage increasing to 58% in 2016. Of the 52 countries that required MDA in 2016, 30 have reached all endemic areas with MDA, 17 are still scaling up in endemic areas, and only five have not yet started MDA.

Treatment should be scaled up in 22 countries to achieve effective MDA coverage in more districts and provide the basic package of care for those with chronic disease.

To improve targeting of interventions, several countries should conduct remapping to confirm the need for MDA. Disappointingly, in 2016, no areas co-endemic for loiasis, located in nine countries, were using treatment with the recommended alternative strategy, posing a great missed opportunity to progress towards elimination in these settings.

2017 has been an eventful year for LF, but there is more to be done and new opportunities to pursue.

10 countries

have now eliminated LF as a public health problem

An exciting advance is the alternative MDA regimen with ivermectin, diethylcarbamazine [DEC] and albendazole (IDA therapy), which was recently approved. WHO has issued guidelines for its use. Merck responded in record time, increasing

their donation to support this new treatment strategy. This provides a unique opportunity, if rapidly adopted, to accelerate progress towards elimination in settings without loiasis or onchocerciasis.

92%

of the evaluation units that have carried out transmission assessment surveys reached the threshold for stopping MDA

More research is needed on ensuring effective MDA coverage, predicting which programmes might not achieve elimination targets. Work to improve diagnostics is required, as results with the Wb123 antibody test, a rapid diagnostic test, were disappointing and will require renewed attention and investment.

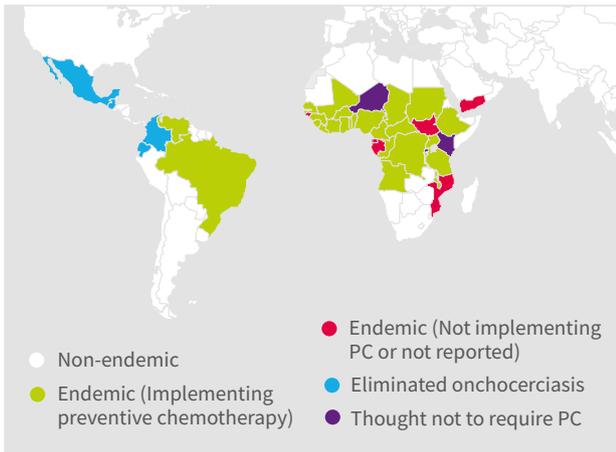
As more countries successfully stop treatment, additional research to better understand feasible protocols for post-MDA and post-validation surveillance are needed so that WHO can issue official guidance to country programmes.



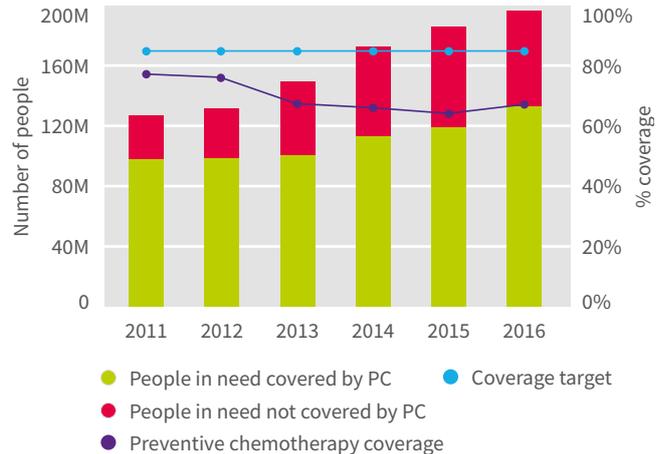
Onchocerciasis

Onchocerciasis (also known as river blindness) is a disease caused by infection with a parasitic worm transmitted by black flies, which breed in fast-flowing streams and rivers.

Onchocerciasis endemicity status (2016)



Preventive chemotherapy coverage¹



WHO roadmap target:

Elimination by 2020

- Latin America by 2015
- Selected African countries by 2020
- Yemen by 2015

The onchocerciasis control programme achieved good coverage through the African Programme for Onchocerciasis Control (APOC) until its closure in 2015.

198 million

people were estimated to require MDA in 2016

Despite the closure of APOC, a greater number of people were reached and coverage increased to 67.1% of the estimated 198 million people in need of MDA. This was the highest coverage of all the PC NTDs in 2016. The impact on disease prevalence is difficult to measure, as operational guidance for impact evaluation is not yet available.

Building on the strong control programme, the recent global strategy outlines a shift in programmatic focus from control to elimination. This introduces new demands such as defining the number of additional areas that will require treatment and appropriate criteria for stopping interventions.

Although many additional districts in a significant number of countries will require MDA, they will theoretically have a lower prevalence and therefore

not require long-term treatment. The drug supply is currently meeting demand but will have to increase to meet the elimination goals. The research agenda should be realigned with the elimination targets, focusing on alternative treatment strategies and new tools for use at points of care. It will have to be translated into

guidelines, in particular to address treatment in settings co-endemic for loiasis.

The operational details of the strategy should be finalized urgently, accompanied by resource mobilization to extend programme capacity and launch interventions coordinated with those for LF.

Encouraging developments since the last report include the creation of national elimination expert committees in Africa and the launch of the Expanded Special Project for Elimination of NTDs in Africa (ESPEN). Technical support to programmes and funding for scaling up treatment are, however, lacking.

Coverage increased to

67.1%

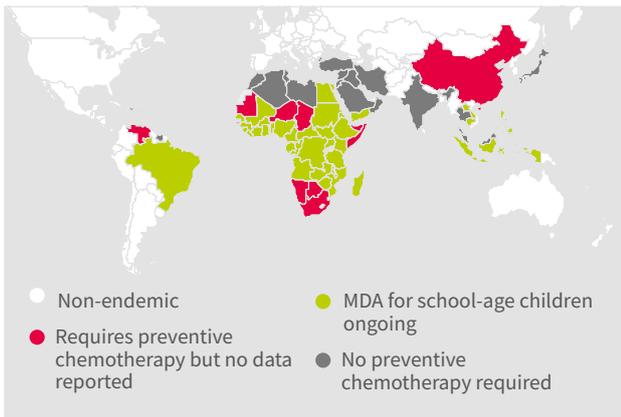
1. The coverage figure is lower than in previous years, partly because the total number of treatments required has increased with the addition of formerly untreated hypo-endemic areas to the treatment area.



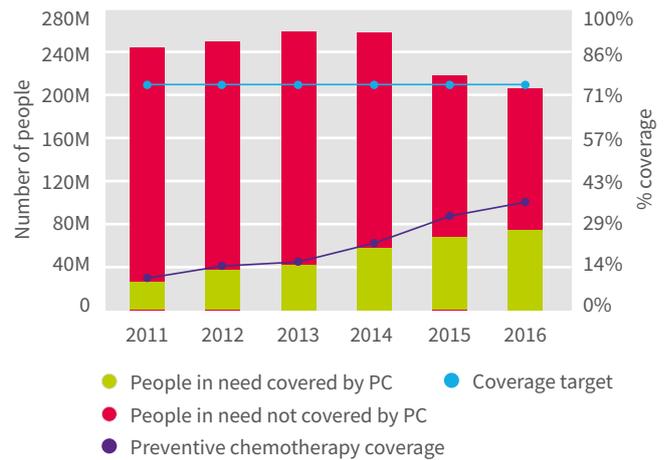
Schistosomiasis

Schistosomiasis (also known as snail fever or bilharzia) is an illness that develops when people come into contact with water contaminated by certain snails carrying the disease-causing parasites, which penetrate the skin and move through the body.

Schistosomiasis mass drug administration status for school-age children (2016)



Preventive chemotherapy coverage



WHO roadmap target:

Control by 2020

- Control morbidity and achieve treatment coverage of at least 75% of all school-age children by 2020
- Regional elimination in the Eastern Mediterranean Region, the Caribbean, Indonesia and the Mekong River Basin by 2015
- Regional elimination in the Americas Region, Western Pacific Region and in selected countries in the African Region by 2020

70.9 million children covered by schistosomiasis programmes

towards the WHO target of 75%. Global population coverage, which includes adults, was however, only 34% in 2016, lagging behind the WHO roadmap target. This is due partly to a shortage of donated drugs for adults.

Progress towards elimination remains elusive as the challenge of truly stopping transmission becomes clear.

This coming year, the focus will be on continuing the increase in population coverage and improving morbidity control and impact assessments.

Guidance to programmes on achieving and measuring elimination is also required, as it is critical to understanding the frequency of treatment, the role of adults in transmission and morbidity, the

focality of transmission for the best use of drugs and the best methods for measuring transmission. New guidance is available on vector control of snails, but new tools and approaches are needed.

27% increase in coverage in 2016 over 2015

The roles of WASH and behaviour change remain to be addressed. The incremental costs and benefits of these tools in both morbidity control and elimination should be debated as we extend the programme and use tools most effectively to achieve the targets.

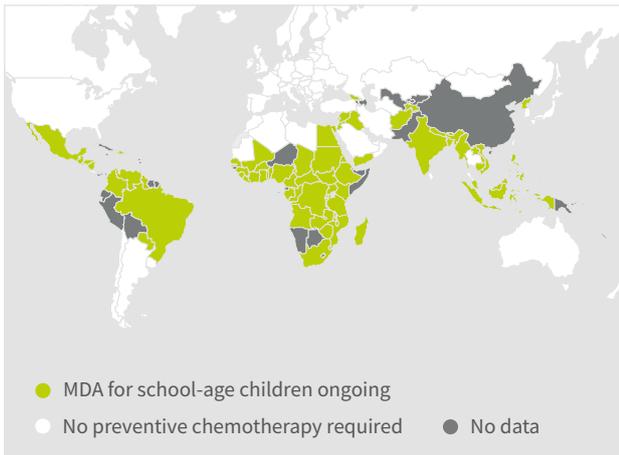
There has been steady growth in population coverage with preventive chemotherapy for schistosomiasis globally over the past 5 years. Most impressive is the dramatic increase in coverage of school-age children with an extended donation of praziquantel. Coverage of children in 2016 was 53.7%, a 27% increase over 2015. The progress means that this fundamental indicator of controlling infection and disease is making progress



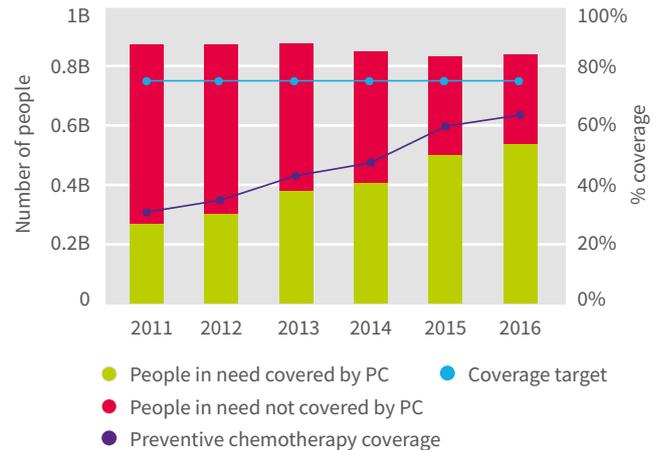
Soil-transmitted helminths (STH)

Soil-transmitted helminths (or intestinal worms) are a group of intestinal parasites that thrive in places where the soil is warm and humid and sanitation is poor. The most common STH-causing parasites are roundworm, whipworm and hookworm.

STH mass drug administration status for school-age children (2016)



Preventive chemotherapy coverage for pre-school and school-age children



WHO roadmap target:

Control by 2020

- 75% of pre-school and school-age children in need are treated by 2020

The global programme passed the half billion mark in 2016, reaching 531 million children in need of deworming. This represents 63% of global need, an increase from 58.5% in 2015. 77 of the 103 endemic countries reported conducting deworming of school-aged children.

531 million

children reached in 2016 by global deworming programmes

The reported coverage of pre-school-age children (51%) was less than that of school-age children (69%), partly because of insufficient drug donation for this group. This is expected to be filled by late 2018. New guidance from WHO in 2017 is to extend treatment

to the estimated 688 million women of reproductive age in endemic areas, 20% of whom are estimated to receive treatment in LF programmes.

With strong programme support, the 10 high-burden countries started deworming, a major step for the global programme. Additional support will be essential to enable the remaining countries to launch control programmes.

The STH community is supporting WHO in developing monitoring and evaluation tools, building on WHO guidance and using the most efficient platforms for reaching women of reproductive age.

While there is a fairly robust research portfolio, including limited studies on elimination, diagnostic tools and drug resistance, there are still not enough new tools to accelerate progress significantly and establish a pathway

77 endemic

countries reported conducting deworming of SAC

688 million

women to benefit from new WHO guidance extending treatment to women of reproductive age

towards elimination. Work is ongoing for assessing pregnancy among women of reproductive age, and additional research is vital for reaching this population.

Additional indicators are required. The forthcoming WHO compendium on STH will provide current guidance for programmes at each stage of control.

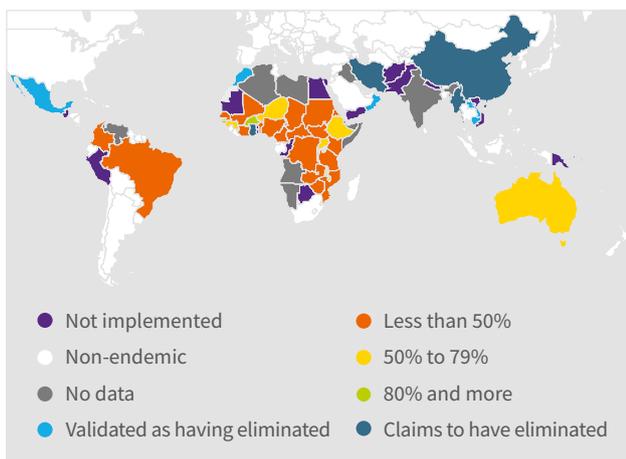
All requests for drugs were met. More requests are expected in order to supply countries that have a smaller burden of these diseases, which have not started deworming. A chewable tablet for preschool-age children is expected to become available in late 2018, which will help to reach this underserved population.



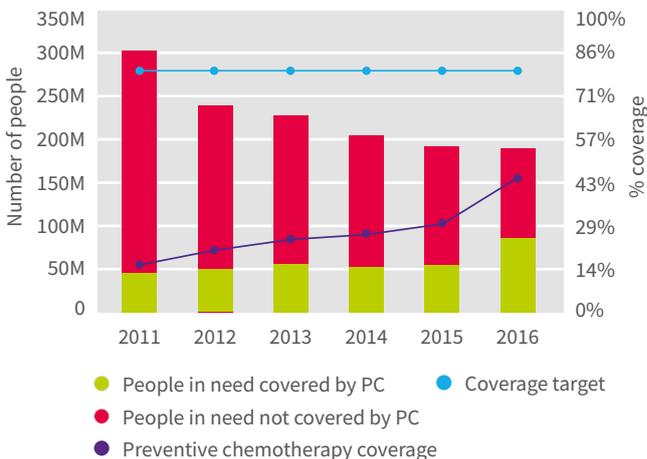
Trachoma

Trachoma is a disease caused by a contagious bacterial infection of the eye, commonly spread through contact with contaminated hands or clothing and by flies coming into contact with a person's eyes or nose.

Trachoma: National coverage (2016)¹



Preventive chemotherapy coverage



WHO roadmap target:

Global elimination as a public health problem by 2020

The global trachoma programme was rapidly scaled up in 2015 and 2016. Antibiotics for trachoma were given to 85 million people in 2016 in the context of the SAFE strategy (surgery for inturned eyelashes, antibiotics, facial cleanliness and environmental improvement). This represented 45% of the population in need and an

85 million

people were treated with antibiotics for trachoma elimination in 2016

80% increase in coverage from 25% in 2014. The number of patients with trichiasis (inturned eyelashes) who were reached with services almost doubled between 2014 and 2016, and five countries have achieved elimination. Despite rapid growth, the programme still has significant

work to do, both in reaching areas still without access to services and in achieving elimination in the areas that are most acutely affected.

The tremendous progress in 2015 and 2016 is due to strong collaboration among all the partners in the global programme. Joint efforts include completion of the Global Trachoma Mapping Project, rapid scaling up of SAFE interventions, preparation of guidelines and an action plan for elimination and strategic coordination of donor work on trachoma in Africa. Nevertheless, resources are urgently required to extend the SAFE strategy to the many areas that still lack access to services, to assess the prevalence of the disease and to undertake operational research.

The newly established Network of WHO Collaborating Centres for Trachoma is coordinating a robust research agenda. Important

80%

increase in antibiotic coverage rates since 2014

questions include post-validation surveillance and progress in areas of high prevalence. Additional resources are essential to move the research programme forward.

500 million

doses donation milestone reached at the end of 2015

Thanks to strong commitment from Pfizer and close coordination with partners, the problems in drug supply reported previously have been resolved, and the antibiotic donation programme has been scaled up for increased implementation. In late 2015, the donation programme celebrated its 500 millionth dose. By the end of 2016, the annual shipment was approximately double the preceding annual averages.

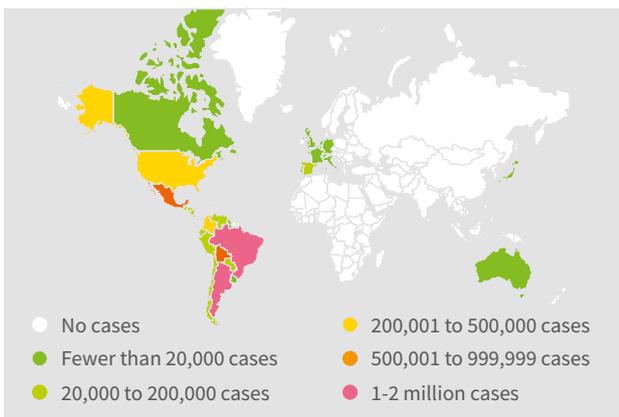
1. People treated with antibiotics for trachoma out of population living in known endemic areas that warrant treatment with antibiotics, facial cleanliness and environmental improvement for elimination of trachoma as a public health problem.



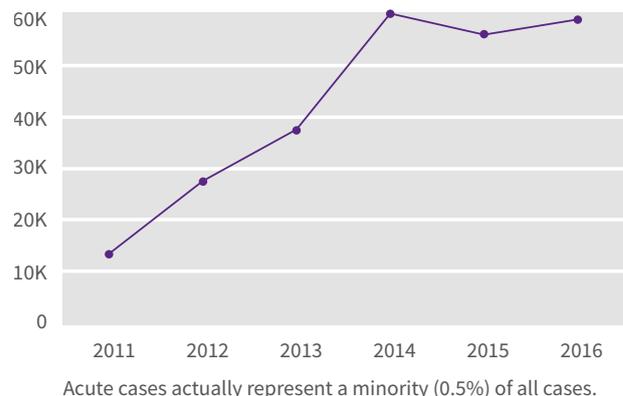
Chagas disease

Chagas disease is a parasitic infection often caused by contact with the faeces of infected blood-sucking insects (called kissing bugs) which infest people's homes. The illness can also be passed on by eating food contaminated by the insects, through blood transfusions or organ transplants, or to children at birth.

Estimated number of people with the Trypanosoma cruzi infection – Chagas disease (2010)



Total number of chronic cases of Chagas disease detected through medical health care systems in endemic countries of the Americas



WHO roadmap target:

Control by 2020

- By 2015, interrupted transmission by blood transfusion in the Americas, European and Western Pacific regions
- By 2020, interrupted transmission by intradomestic vectors in Latin America

Progress in controlling Chagas disease has been most impressive in endemic settings in Latin America. Good progress was made towards interrupting transmission from both blood transfusions and bites from the vector. Almost all countries (41 of 42) conducted compulsory screening to interrupt transmission during blood transfusion however, verification of interruption is lengthy and costly and will take longer to complete. Similarly, progress in halting household transmission from triatomine bugs by 2020 is on track, 9 of 21 countries having halted transmission and a further 8 having achieved partial

interruption by 2015. Three areas that present particular challenges for reaching vector control targets are the Amazon basin and Gran Chaco regions of South America and the Guatemala–El Salvador border. Conducting activities is logistically challenging and expensive and requires more support.

Individual diagnosis and treatment are integral components of the global programme. Support has increased but is still far short of that needed. It has been reported that less than 1% of patients globally can access treatment. Recent commitments by endemic countries to scale-up diagnosis and treatment are promising but will require resources. NGOs have increased their support in this area, approximately doubling the number of patients diagnosed and treated between 2015 and 2016, and have extended their support to 10 countries. Coordination with WHO and the WHO Regional Office for the Americas has increased and should continue. Global requests have been made for nifurtimox, and benznidazole is now approved for

9 countries

have halted vectorial transmission

use in the USA; more detection and treatment in the USA is therefore anticipated. A commitment from Mundo Sano and Elea to donate treatment for Chagas disease for congenital cases in Latin America (in agreement with the WHO Regional Office for the Americas) and for children under 18 in countries outside of the Americas (in agreement with WHO) is a significant advance.

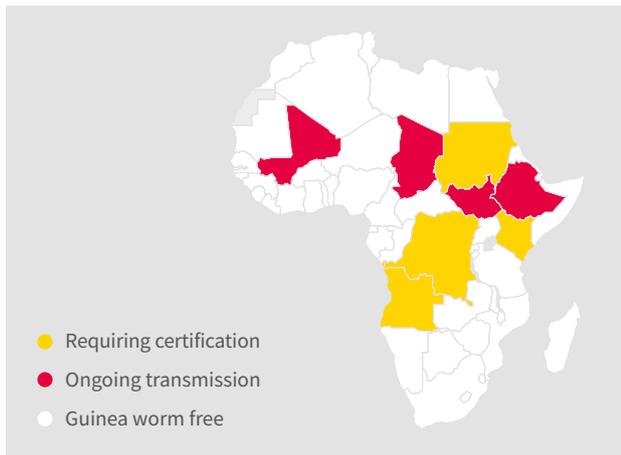
The urgent unmet research needs in the global Chagas disease programme include monitoring of and research on insecticide resistance; new diagnostic tools more appropriate for the programme, such as rapid tests for inaccessible areas; better tools for diagnosis in newborns; improved access to diagnosis and treatment; and alternative drugs for patients with long-term Chagas infection or other conditions that cannot be treated with current therapy.



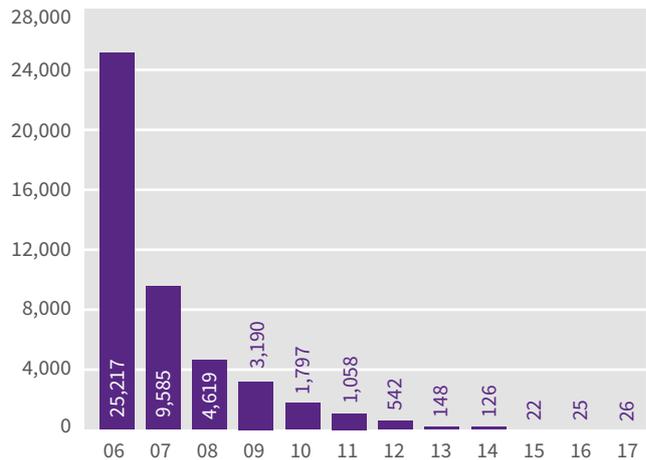
Guinea worm disease

Guinea worm disease (also known as dracunculiasis) is an incapacitating parasitic illness caused by drinking water that contains water fleas infected with Guinea worm larvae.

Status of Guinea worm disease eradication (2017)



Number of Guinea worm disease cases by year



WHO roadmap target:

Global eradication by 2020

The global Guinea worm eradication programme is increasingly close to eradicating the disease, with only 12 laboratory-confirmed cases globally at the time of scoring. As of 31 October 2017, 14 confirmed cases had been reported from Chad and one from Ethiopia. An additional 11 suspected cases (yet to be laboratory confirmed) have been reported from

Zero

cases reported during the past 23 consecutive months from Mali

an outbreak in Ethiopia, bringing the provisional total cases to 26, from two countries. No human cases have been reported during the past 23 consecutive months from Mali or from South Sudan during the past 11 months, whereas 19 cases were reported during the same period in 2016. This impressive progress in Mali

and South Sudan was achieved under very difficult circumstances.

The main challenge to the programme is transmission in Chad. Additional interventions to understand and control transmission in this country remain a priority. Infections in dogs are a concern, and these continued in Chad (750), Ethiopia (11) and Mali (8). Although a 20% decrease was observed during January–September 2017 from the same period in 2016, it is too early to determine whether the trend will continue. There is evidence that exposure to paratenic host due to eating improperly cooked, cured or fresh aquatic animals containing infective larvae of *Dracunculus medinensis* may be contributing to transmission in Chad. This led the programme to recommend cooking aquatic animals well before eating them and burying or burning fish entrails so that dogs do not eat

98%

decrease in Guinea worm disease cases, from 1,060 in 2011 to 26 cases in 2017

them. The programme provided a cash reward of US\$ 20 for containing infection of dogs by tethering them. These actions are believed to be responsible for the observed decrease in dog infections and emerging Guinea worms. Greater use of larviciding is being discussed.

The aim of national programmes is to interrupt transmission by 2020, but persistent armed conflict in areas under surveillance threatens interruption of transmission and the ability of countries to achieve certification.

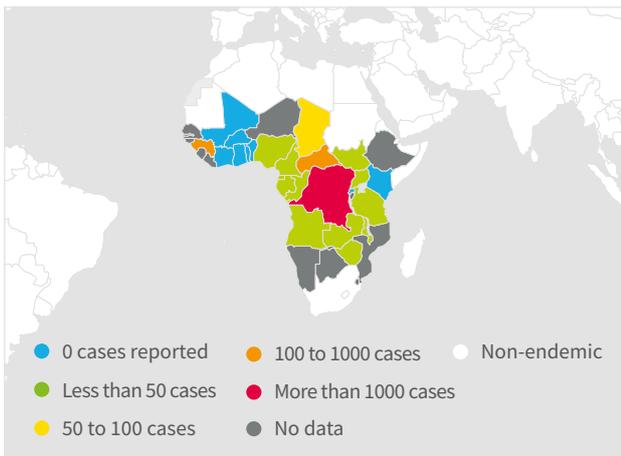
A research programme is being conducted to identify when, where and how animal infections occur in Chad, Ethiopia and Mali and the role in ongoing human transmission. The studies include genetic characterization of Guinea worm populations, studies on dog-human behaviour and risk factors, the possibility of paratenic host transmission and trials of dog treatment.



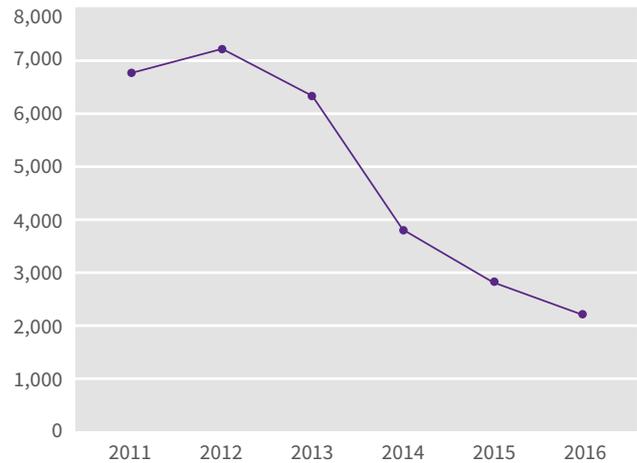
Human African trypanosomiasis (HAT)

HAT (also known as sleeping sickness) is caused by an infection, with parasites transmitted to humans through the bites of infected tsetse flies. The disease manifests in two forms: chronic infection with *Trypanosoma brucei gambiense* (g-HAT) and acute infection with *T. brucei rhodesiense* (r-HAT).

New cases of HAT reported in 2016



Number of new cases of HAT reported per year



WHO roadmap target:

Global elimination as a public health problem by 2020

The steady decrease in the global number of new patients with human African trypanosomiasis (HAT) continued in 2016, strongly suggesting that the programme will meet its 2020 elimination target, defined as fewer than 2,000 cases reported globally. Only 2,184 cases were reported in 2016, after screening some 2.3 million people in a robust programme that

68%

reduction in the number of cases for HAT from 6,747 in 2011 to 2,184 in 2016

reached thousands of villages in logistically challenging locations at risk for HAT. This provides assurance that the decreasing number of new cases is not due to under-detection.

The Belgian government pledged significant new support this year, leveraging additional support from the Bill & Melinda Gates Foundation. In addition, during 2015 and 2016, WHO convened several meetings of the WHO Network for HAT Elimination, a large multi-sectoral partnership of stakeholders. The network strengthens collaboration and supports national programmes by leading and coordinating the actions of all stakeholders in each endemic country. Strategic advances in monitoring, evaluation and data management have also been seen.

WHO has introduced new indicators and has trained national data managers, resulting in better information on populations and areas at risk and on access to diagnosis and treatment. This will help the programme to target surveillance and interventions. Programmes

2.3 million

people were screened in 2016

should nevertheless use vector control to supplement case detection and treatment as part of the elimination strategy. Furthermore, programme expertise should be made available to country health systems, including peripheral health centres, to prevent the disease from reappearing after elimination.

The results of research on a new oral treatment are anxiously awaited, as there are serious problems with current therapy, which requires intravenous infusion by skilled personnel

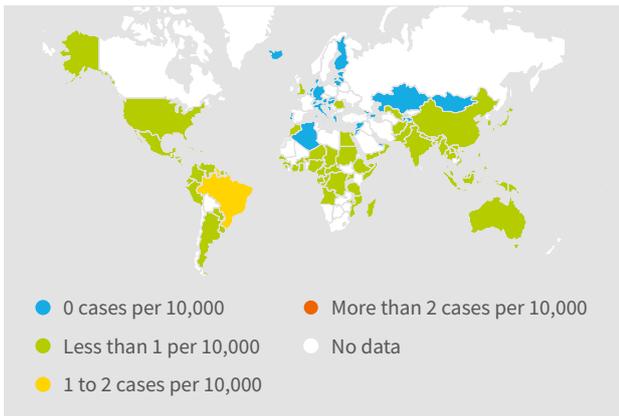
The new generation of rapid diagnostic tests has increased surveillance, but additional steps are required for verification of positive test results. Research is under way on asymptomatic human carriage and animal reservoirs, new diagnostic tools for surveillance in elimination settings, and HAT and NTD modelling by consortia to support country and global programme decision-making.



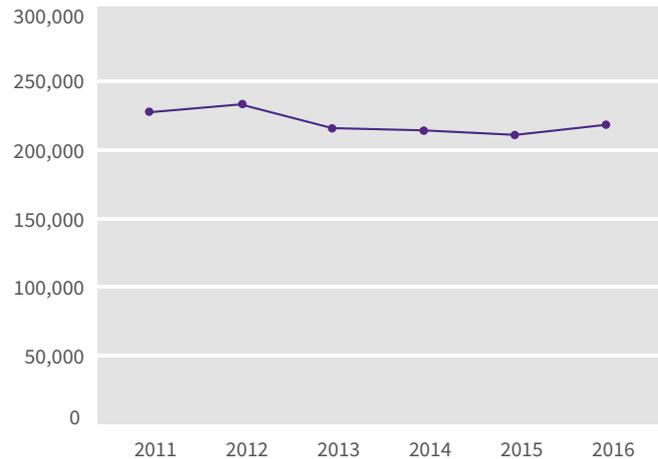
Leprosy

Leprosy (also known as Hansen’s disease) is a chronic infectious disease caused by bacteria mainly spread through droplets from the nose and mouth of people suffering from untreated leprosy (produced when they sneeze or cough).

Leprosy: Registered cases per 10,000 population – prevalence rates (2016)¹



Number of new cases of leprosy reported per year



WHO roadmap target:

Global elimination by 2020

A slight increase in the number of new cases was seen between 2015 and 2016, which may be due to intensified active case detection. The persistent incidence of new cases, a substantial proportion of whom are children, is concerning and indicates that progress towards the interruption of transmission has halted. The concern is exacerbated by the detection of new patients, including children, who already have disabilities caused by leprosy.

The situation varies widely by country, and several that were previously highly endemic are approaching zero incidence.

Treatment of cases and their contacts may become important in stopping transmission but is still in the early stages and in only a limited number of countries.

All requests for drugs in 2015 and 2016 were filled by the manufacturer, which pledged to supply multi-drug therapy for all new cases through 2020. The programme has made progress in supporting morbidity management and social inclusion. The number of countries that reported access to wound care and community rehabilitation for patients living with leprosy-related disabilities has met the targets set for 2016.

There was good progress in global leadership from WHO and collaboration among partners to develop a new global strategy for 2016–2020, with operational guidelines and a monitoring and evaluation framework.

The main problems identified include continued transmission, slow case detection and social exclusion, which not only causes suffering but facilitates transmission by delaying detection of the disease and interrupting treatment.

The main challenge for the programme is the absence of a diagnostic tool; simplified therapy would also be an advantage. A better coordinated research strategy on diagnostics will be critical but will require mobilization of significant resources. Interruption of transmission will be unlikely without good coverage of the population at risk with preventive chemotherapy and/or a vaccine.

Tools are needed to measure infection in order to verify that transmission has been interrupted.

Studies on vaccines and preventive chemotherapy are currently under way. These problems will be addressed through a coordinated strategy for a ‘global partnership for zero leprosy’.

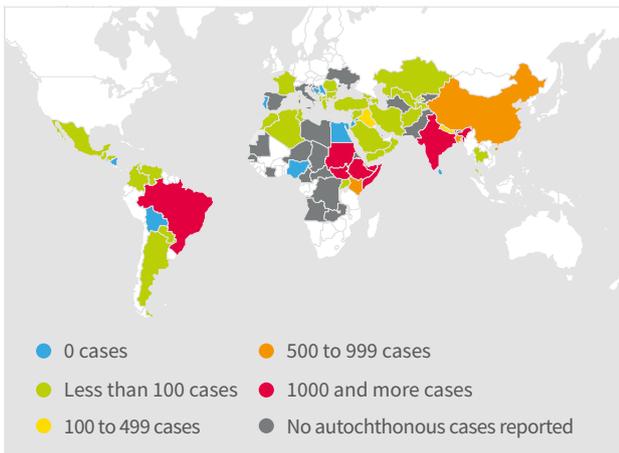
1. Only Comoros, Kiribati, the Marshall Islands and Micronesia have more than 2 registered cases per 10,000.



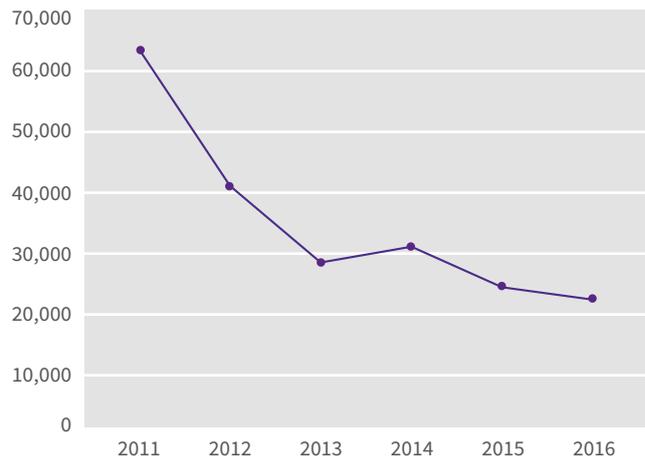
Visceral leishmaniasis (VL)

Visceral leishmaniasis (also known as kala-azar) is caused by infection with leishmania parasites through bites of infected sandflies that breed in and around homes or farms.

Visceral leishmaniasis: Number of cases reported¹



Numbers of cases of VL reported



WHO roadmap target:

- Regional elimination on the Indian subcontinent by 2020
- Achieve 100% case detection and treatment

The VL programme has achieved a sustained decrease in the number of cases reported globally during the past 5 years, and the decrease in global case fatality rate has met the target through a strategy of case detection, treatment and vector control.

The Indian subcontinent is on track to achieve its elimination target, with incidence rates dropping steadily and an increasing number of districts declaring that the disease had been eliminated as a public health problem.

WHO, with endemic countries and partners, has significantly improved data management over the past 5

years, regularly collecting, analysing and disseminating data from the programmes in the 25 high-burden countries. More resources for data collection and management at national level would help reduce data reporting delays and gaps and further enhance surveillance and effective targeting of interventions.

The programme on the Indian subcontinent is supported by many stakeholders. Support is managed in countries in regular coordination meetings of national programme managers. Active screening, a vital programme activity, is supported by partners, although cases are under-reported. Thus, better data management at national level is required to make data available for monitoring, evaluation and planning and recognition of under-detection rates.

Research on vector control is important, especially as the vector is now showing resistance to insecticides.

New diagnostic tools would facilitate early diagnosis and reduce transmission. The treatment currently used on the Indian subcontinent is difficult to administer and ill-suited for use in remote health care facilities.

In addition, the treatment is not highly effective in African VL, and safer treatment that is easier to administer would accelerate achievement of the programme goals.

Improved and more effective surveillance will be critical to achieve and sustain elimination, given reducing case numbers.

All requests for AmBisome® were filled by Gilead and, in late 2016, the company signed a new 5-year agreement to donate drugs and to fund better tools for diagnosis and treatment.

1. Based on the best available data at the time of reporting (2015 and 2016 data)

Scorecard

The Uniting to Combat NTDs scorecard was compiled to follow progress towards the goals of the WHO roadmap and the contributions of partners. The scorecard comprises a collection of multiple indicators that were designed by WHO and partners to provide an annual view of the status of each disease. Over the past five years, the scorecards have provided a snapshot of where we stand and where action is required to adjust the course.

In the future, we would like to move past this compilation of indicators towards a more dynamic tool that still follows progress and indicates where work is required but which could evolve as new targets are set and indicators identified. Most importantly, we would like to manage the scorecard and its collective action to accelerate progress and to make it the most refined advocacy tool possible – one that will more clearly display progress and highlight gaps.

During the past year, we took a close look at the scorecard, the indicators, the logic behind them, the scoring process, potential uses and the most relevant audience. With this proactive strategy, we sought ways to strengthen the scorecard. We have begun to engage the broader Uniting partnership in this process, to ensure that the scorecard meets our collective needs.

The sixth scorecard will be updated following consultations with our partners and be even more powerful in helping us support countries and communities in achieving their NTD and UHC goals. If you would like to learn more or offer input, please do not hesitate to contact the support centre at scorecard@unitingtocombatntds.org.



5th Scorecard on Progress

London Declaration NTDs		Coverage and impact milestones	Program support milestones	Drug requests filled	Research	Overall progress
Preventive chemotherapy (PC)	Lymphatic filariasis	2	2	1	1	2
	Onchocerciasis	2	2	1	2	2
	Schistosomiasis	3	2	1	3	3
	Soil-transmitted helminths	1	1	1	2	1
	Trachoma	2	2	1	2	2
Innovative and intensified disease management (IDM)	Chagas disease	2	2	1	3	2
	Guinea worm disease	2	2	not applicable	2	2
	Human African trypanosomiasis	1	2	1	2	1
	Leprosy	3	2	1	2	2
	Visceral leishmaniasis	1	2	1	2	1

- 1** Achieved or minor delay; or 90–100% of requested treatments shipped
- 2** Delayed but achievement anticipated; or 80–89% of requested treatments shipped
- 3** Delayed, additional action required; or 0–79% of requested treatments shipped

Scorecard summaries

Lymphatic filariasis

2 2 1 1 2

While the programme had a strong impact in terms of the number of communities that met the criteria for stopping MDA, the overall score was yellow, because 22 countries are not anticipated to achieve the 2020 goal unless they adopt new strategies. MDA coverage was extended from 40% in 2011 to 58% in 2016; thus, the programme must find ways to reach all the affected populations with MDA, morbidity management and disability prevention. The move from early research to WHO recommendations was completed in record time, which will accelerate progress towards elimination; this was due to the strong partnership of many stakeholders and WHO. Success in 2018 will depend on scaling up administration of both ivermectin, diethylcarbamazine and albendazole (IDA) and twice yearly albendazole where loiasis is also endemic. Additional support is still needed for research on diagnostics and methods for post-validation surveillance.

Onchocerciasis

2 2 1 2 2

Overall, the onchocerciasis programme was scored yellow to reflect the transition from a strong disease control programme to an elimination programme with significant areas of uncertainty. A new strategy will be required to confirm whether treatment is needed, how to treat onchocerciasis in areas co-endemic for loiasis and how to determine when communities can stop interventions. Despite the good progress, more guidance should be given to countries during this transition, and guideline development should be accelerated, including on coordinating activities with those for lymphatic filariasis. Mapping must be completed, and funding is urgently required to strengthen programme capacity and launch interventions.

Schistosomiasis

3 2 1 3 3

The schistosomiasis programme is still scored an overall red because, although elimination remains the stated target, there has been no significant, measurable progress. Despite this score, impressive progress has been made towards controlling morbidity, with the scaling up of treatment of school-aged children with donated praziquantel. A focus on morbidity control and better measures of progress towards this target would more accurately reflect the progress made in the

programme. More research is urgently required on more effectively controlling morbidity, with the eventual goal of contributing to the elimination of schistosomiasis. Further studies should be conducted on behaviour change, therapies, vector control and WASH and on new tools that the programme will require to move from control to elimination.

Soil-transmitted helminthiasis

1 1 1 2 1

As the programme is showing steady progress and improvement overall and is on track to achieve the 2020 target, it was scored green. A major milestone was initiation of deworming in all high-burden countries. WHO recently revised the programme guidelines to include women of reproductive age among those who should be treated, and the soil-transmitted helminths community is collaborating to meet this operational challenge and to ensure that the guidance for each phase of the programme is more accessible. The drug supply has been scaled up, in keeping with the demand of the growing programme. Research on these diseases was scored yellow because the current portfolio does not include any drugs or methods that would significantly accelerate progress towards achieving the targets.

Trachoma

2 2 1 2 2

The programme has grown significantly and performed well; however, it was scored yellow overall because the roadmap targets for 2020 will probably take longer to achieve. The exceptional growth is due to strong collaboration among all partners on critical strategic projects, such as global disease mapping, funding for interventions, preparation of surveillance guidelines, an action plan for global elimination and donor coordination on Africa. The remaining challenges are to identify funding in order to reach all the communities that require interventions, to ensure funding for assessing impact and to solve important research questions.

Chagas disease

2 2 1 3 2

On the fourth scorecard, the programme for Chagas disease was scored red, mainly due to lack of data and unclear indicators for following progress. This year, better data were available and there was more discussion on the significance of the data, with collaboration between WHO and the Chagas disease community. Overall therefore,

the programme was scored yellow. Impressive progress has been made in Latin American countries in which the disease is endemic, with prevention of transmission from bites of the vector and promising steps towards preventing transmission from blood transfusions. Continued engagement with the Chagas disease community and WHO will provide a better picture of progress made and the challenges to moving forward.

Guinea worm disease

2 2 - 2 2

The Guinea worm disease programme was scored yellow. Good progress was made towards the new 2020 elimination goal, but cases are still occurring in Chad, a new potential outbreak began in Ethiopia, and cases continue to be found in dogs. This year the number of dog infections fell by 20% between January and September 2017 compared with the same period in 2016. Good progress was made in Mali and South Sudan, with no cases reported. Programme support remains strong, with sustained funding for the campaign and good collaboration among stakeholders on cross-border issues and research. Insecurity and population displacement remain significant challenges. The robust research programme has yet to find how dogs are infected. The overall score of yellow reflects continued progress towards zero human cases in Mali and South Sudan; however, cases persist in Chad, with no improvement over the past few years. Animal infections and lack of security are unpredictable external challenges that will have to be overcome for the final stage of the programme.

Human African trypanosomiasis

1 2 1 2 1

Overall, the programme was scored green, in light of the likelihood of meeting the 2020 goal of fewer than 2,000 cases globally. The targets for coverage, impact and drug supply are all on track and were scored green. Programme support and research were scored yellow. It will be critical to maintain stakeholder momentum, introduce and consider new tools, even as case numbers continue to fall, in order to avoid the very real possibility of recrudescence. This tragic scenario has already occurred once, when the disease re-emerged in the 1980s after near-elimination in the 1960s. Activities must be integrated into peripheral health facilities and country health systems during the next few years. Diagnostic and treatment options that are easier to use are required to support the transition and to ensure that elimination is sustainable.

Leprosy

3 2 1 2 2

Overall, the leprosy programme was scored yellow. A slight increase in the number of new cases was seen between 2015 and 2016, which was however, attributed to intensified active case detection. The score was based primarily on the persistent occurrence of new cases and continued detection of new patients, including children, who already have disabilities caused by leprosy, indicating late detection. The new global strategy 2016–2020, supplemented by operational guidelines and a robust monitoring and evaluation framework, will provide solid guidance to countries and better coordination among partners for a strategic approach to reduce incidence, will result from the ‘global partnership towards zero leprosy’.

Visceral leishmaniasis

1 2 1 2 1

Overall, the programme was scored green because of continued, strong progress towards the WHO targets for elimination on the Indian subcontinent, with an increasing number of districts declaring elimination. There has been a sustained decrease in the number of cases reported globally, and the global case fatality rate is on target, although there is some concern that the fatality rate may be underestimated because of attribution of deaths to other acute causes. WHO has significantly improved data management during the past 5 years, but more resources for data collection and management at national level would enable the system to achieve its potential, particularly with regard to data on active screening. Research is required urgently on vector control, the role of asymptomatic and post-kala-azar dermal leishmaniasis in sustained transmission, diagnostic tools that are easier to use and treatment that is easier to administer. The requests for AmBisome® were met, and this aspect was scored green. Gilead Sciences signed a new 5-year agreement for drug donation and funding for better diagnosis and treatment in late 2016.

Call to action

Neglected Tropical Disease (NTDs) programmes reached over 1 billion people in a single year. Now, we must beat that record and reach the rest of the 1.5 billion people in need of treatment.

Great progress has also been made in control and elimination: several diseases are at their lowest levels in recorded history and more than a dozen countries have eliminated at least one NTD in the last several years. Nevertheless, as we approach 2020, it is clear that we will not meet all our targets. To build on our progress, we need new tools, new resources, and new approaches.

The next steps should involve the wider community to ensure the access of marginalized populations with NTDs. Universal health coverage (UHC) can become the next step to providing targeted health services for all, including those who are hard-to-reach. We should build on the momentum and use the opportunities created through the NTD platform to ensure no one is left behind.

We call on endemic countries to:

- increase domestic financial and political commitment to NTDs
- scale up programmes and reach all those at risk
- invest domestic resources in fighting NTDs
- complete and more timely, report programme data disaggregated by age and sex from district level to ensure that no one is left behind
- incorporate new tools such as new triple-drug therapy for LF and tiny targets for sleeping sickness into national strategies and deploy them widely and rapidly to the field

We call on the World Health Organization to:

- maintain the momentum in the fight against NTDs as the 2020 WHO roadmap targets approach, and work towards the fulfilment of the Sustainable Development Goals (SDG3) target for NTDs
- commit itself to goals of the NTD roadmap and to new goals beyond 2020
- prepare recommendations on how best to transition from donor-supported initiatives to national platforms for UHC

We call on existing and new donor countries including private philanthropy to:

- invest in NTD elimination. Support for NTD programmes is one of the best buys in development. NTD programmes leverage billions of dollars' worth of donated drugs, multiplying the impact of every dollar committed. Every dollar invested in NTD control and elimination has an economic return of US\$ 27 and \$ 42
- stay the course until these diseases are eliminated, and encourage new donors to join this global effort

We call on programme implementers and NGOs to:

- work with the health system to strengthen it and ensure that morbidity management does not fall behind treatment as we move boldly ahead
- document successes as countries achieve their elimination targets and learn, duplicate and scale up best practices while taking time to celebrate progress.

Together, we can reach our goals and build a better, fairer and healthier world.

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