REPORT OF THE GLOBAL PARTNERS’ MEETING ON NEGLECTED TROPICAL DISEASES

Geneva, Switzerland
19–20 April 2007

A turning point 2007
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Acknowledgements

The meeting of global partners on neglected tropical diseases is a positive sign that health is a responsibility shared by the international community.

The Department of Control of Neglected Tropical Diseases of the World Health Organization wishes to thank partners in Member States, United Nations agencies, nongovernmental organizations and colleagues in the WHO Regions for their generosity, support and hard work.

Special thanks are extended to Professor David W.T. Crompton of the University of Glasgow, Scotland and to Mrs Patricia Peters, Kirriemuir Secretarial, Glasgow, Scotland for their major contribution to the development of this report.
Neglected tropical diseases

An estimated one billion people – one sixth of the world’s population – are infected with one or more neglected tropical diseases. These diseases are largely ancient infectious diseases that thrive in impoverished settings, especially in the heat and humidity of tropical climates.

The list of neglected tropical diseases is not exhaustive and has regional and national variations. Initially, WHO will focus on control of the following diseases:

- Buruli ulcer
- Chagas disease
- Dengue/dengue haemorrhagic fever
- Dracunculiasis (guinea-worm disease)
- Endemic treponematoses (yaws, pinta, endemic syphilis…)
- Human African trypanosomiasis (sleeping sickness)
- Leishmaniasis
- Leprosy
- Lymphatic filariasis (elephantiasis)
- Onchocerciasis
- Schistosomiasis
- Soil-transmitted helminthiasis
- Trachoma

“Neglected Tropical Diseases
Hidden successes
Emerging opportunities”
Form and structure of the Partners’ Report

The Global Partners’ Meeting on Neglected Tropical Diseases was held at WHO headquarters in Geneva, Switzerland, on 19–20 April 2007. Some 200 participants attended the meeting, including representatives of WHO Member States, United Nations agencies, the World Bank, philanthropic foundations, universities, pharmaceutical companies, international nongovernmental organizations and other institutions dedicated to contributing their time, efforts and resources to control neglected tropical diseases. This meeting declared to the world that control of these diseases deserves high priority on the global public health agenda and still greater determination to deliver appropriate health care to the millions of poor people in need.

The vision, commitment, determination and steps forward were highlighted by the inspiring declarations of His Excellency Mr Blaise Compaoré, President of Burkina Faso, and His Excellency Dr Ali Mohamed Shein, Vice-President of the United Republic of Tanzania.

The form and structure of this report has evolved from the opening speech delivered by Dr Margaret Chan, WHO Director-General. Its theme – that the meeting marked a turning point in the long and notorious history of some of humanity’s oldest diseases – has been developed to emphasize where circumstances and conditions are being transformed by governments and their partners to bring relief from the ravages of these diseases.

The material provided by representatives during two days of extensive debate, where verbal or actual, was recorded. This report does not contain all these contributions. Rather, it presents selected quotations arranged by subject matter. Although some minor editing was required for conformity with WHO house style, most of the quotations are presented verbatim and in alphabetical order by the speakers’ institution or the government ministry.

No attempt has been made to prioritize the order of the material presented or to suggest that some quotations are more important than others. Each unique contribution is of value and served to emphasize the sincere commitment of all partners to advance the control of neglected tropical diseases.

Secretariat
World Health Organization
Geneva, Switzerland
A vision to relieve the burden of Neglected Disease

Opening speech

Dr Margaret Chan, Director-General, World Health Organization

Excellencies, distinguished ministers of health, representatives of industry, colleagues in health and development, ladies and gentlemen.

This meeting – the first event of its kind – marks a turning point in the long and notorious history of some of humanity’s oldest diseases.

Gathered in this room are scientists who have spent their careers unravelling the complexities of these diseases.

Political leaders and ministries of health in endemic countries are present, demonstrating the level of commitment to diseases that almost exclusively affect poor and powerless people.

Development agencies, foundations and implementing agencies are likewise represented. Your sustained support is a sign of our shared concern and our solidarity in matters of health.

The burden imposed by these diseases, measured in terms of human misery alone, is unacceptable. We are committed to take action.

Industry is present. Your donations of drugs and other support opened an opportunity which public health has seized.

Your engagement has given us the tools to take action on an unprecedented scale. We have set ambitious goals and supported these with technical strategies for implementation.

Together, we are upholding a fundamental principle of health development: equity. Access to life-saving and health-promoting interventions should not be denied for unfair reasons, including an inability to pay.

We welcome other United Nations agencies. These diseases have international importance in sectors well beyond health.

Finally, we can welcome the World Bank and the development banks of Africa and Asia. There are economic consequences as well. We have solid evidence that these diseases hold back economic development in many significant ways.

I have described this meeting as a turning point. Why have these diverse interests converged in this room today? This is indeed a prestigious gathering for diseases historically prone to neglect.

I can offer a few explanations. One concerns the altered landscape of public health at the start of this century.

In just the past decade, health has achieved unprecedented prominence as a key driver of socioeconomic development. This prominence is formally expressed in the Millennium Development Goals, which recognize the two-way link between health and poverty, and give health development a central role to play.

The neglected tropical diseases express this link between health and development in an explicit, almost visual way – a way that is more compelling than statistics alone.

Conditions of poverty perpetuate these diseases, while the health impact of these diseases perpetuates poverty. This strong association with poverty is readily apparent from just a few examples. Some forms of African sleeping
sickness and leishmaniasis are 100% fatal if not detected and treated in time. All of the other diseases debilitate, blind or maim, permanently curtailing human potential and impairing economic growth.

This is not difficult to understand. People whose limbs are deformed, and people who have been blinded by disease will not contribute fully to society and economies.

The drain on productivity is enormous. More than one billion people are affected. These people are a double burden for society. They cannot work to full capacity, and they require chronic care.

The costs of care can bankrupt households. Stigma and social isolation, especially for women, compound the misery and further embed people in poverty.

These diseases are also a burden for health systems. For many other infectious diseases, management is an intermittent emergency. The patient either survives or dies. This is not the case for these diseases, where the misery is prolonged.

Hospitals are burdened by patients whose internal organs have been permanently damaged by parasites. For some severe consequences of Chagas disease, the only truly effective treatment is a heart transplant. Surgical treatment of advanced Buruli ulcer requires weeks – if not months – of hospital care.

The burden of these diseases on a population can increase dramatically when an epidemic-prone disease of poverty, such as cholera, causes explosive outbreaks.

This clear association with economic burdens has proved important in a climate of international commitment to poverty reduction. It has given these diseases an added dimension, and it has elevated their standing on the development agenda.

But it took more than an association with poverty to bring us to this room. There are other reasons why these diseases, so long ignored, are now receiving the attention they deserve. The prospects for reducing the enormous burden caused by these diseases have changed dramatically in just the past few years. We can identify a succession of well-planned actions, firmly rooted in evidence, which paved the way forward. These actions hold lessons for other areas of public health, and deserve a brief review.

First, a major step was to view these diseases as a group. This makes practical sense in operational and strategic terms. Strongly associated with poverty, these diseases frequently overlap geographically, with as many as six major diseases present in large parts of the world. Although medically very diverse, all of these diseases thrive under conditions of poverty and filth. They tend to cluster together in places where housing is substandard, drinking-water is unsafe, sanitation is poor, access to health care is limited or non-existent, and insect vectors are constant household and agricultural companions.

This geographical overlap means that people are often affected by more than one disease. It also means that strategies developed to deliver interventions for one disease can rationally be used to deliver interventions for others. This opens opportunities for integrated approaches, for simplification, cost-effectiveness and streamlined efficiency.

We must not forget: we are dealing with neglected populations as well as neglected diseases. These people usually live in areas not covered by formal health services, and are notoriously difficult to reach.

When these diseases are viewed together, we gain critical mass. We get a better grip on the scale of the economic and social as well as the health burdens. Arguments for giving these diseases higher priority become more powerful, more persuasive. As yet another advantage, grouping these diseases together creates opportunities for the sharing of innovative solutions, especially as most control programmes face similar operational constraints.

For example, the dose-pole was pioneered by the onchocerciasis control programme as a way to determine drug dosage, by height, for ivermectin. This innovation is now being used for schistosomiasis control, where praziquantel is administered in remote settings by non-specialized staff.

As a group, these diseases can participate in a shared momentum, where success for one disease spills over to benefit others. The eradication of guinea-worm disease is now in sight, despite the absence of a vaccine or curative drugs.

This success shows the feasibility of behavioural change in remote rural areas and the power of education to achieve this change. This is a strong message for many other health initiatives. Behavioural change is feasible and health education works, even in poor and illiterate villages. As a second step forward, expert consensus on control strategies was reached, and this carries weight. The first Berlin meeting on neglected tropical diseases, held in December 2003, was a stock taking event, an inventory of needs, potential and impediments to success.

At that time, the very low place of these diseases on national and international development agendas was identified as the principal reason...
so little progress was being made – despite the availability of powerful interventions.

Sixteen months later, when the second Berlin meeting was held in April 2005, the reasons for this neglect had been addressed, the arguments were ready and the stage was set for action. Associated as they are with extreme poverty, these diseases share common determinants and must overcome similar obstacles to control. It thus makes sense, in an action-based strategy, to group the diseases according to shared operational and programmatic needs.

Two broad groups of disease were defined at the second Berlin meeting. The first includes diseases having rapid-impact interventions: drugs so safe and so powerful they can be administered to all at-risk populations. The emphasis here is on morbidity control, reducing the pool of human infection and thus reducing levels of transmission. This was a breakthrough, made possible by good drugs supported by industry donations. The option of mass preventive chemotherapy obviates the need for case-finding and diagnosis. It greatly simplifies operational demands and opens the way for integrated approaches. This is a population-wide approach: no one is excluded for unfair reasons. Nor is poor access to health services an absolute barrier. Many of these control strategies require only once-yearly contact with health services.

The second group includes more challenging diseases – the diseases that cannot be treated under a tree.

For diseases such as African sleeping sickness, leishmaniasis, Chagas disease and Buruli ulcer, the focus is on better case detection and clinical management. Dramatic steps forward must await the development of better diagnostics and drugs. These must be affordable and suitable for use under field conditions.

The next step came last year, when WHO and multiple partners launched an integrated strategy for preventive chemotherapy for four of the highest-burden tropical diseases: lymphatic filariasis, onchocerciasis, schistosomiasis and soil-transmitted helminthiasis. Blinding trachoma opens the way for integrated approaches. The option of mass preventive chemotherapy also made populations receptive to subsequent campaigns.

Viewing these diseases as a group and getting consensus on control strategies has been extremely important. It has moved these diseases from the debit to the credit side of the public health balance sheet. Instead of being seen as a permanent burden to be endured – the inevitable companions of inevitable poverty – these diseases can now be viewed as an opportunity for improving the lives and the productivity of more than one billion people.

As a third contributing factor, recent research has demonstrated the much larger significance of these diseases. Their impact on productivity has long been known, but remained poorly quantified until very recently.

For example, in 1949, a year after WHO was established, a first expert consultation on schistosomiasis was held. The experts noted that this disease affects the physical and mental development of children and greatly diminishes the strength and productive power of adults. As they further concluded: it does so in ways that markedly diminish food production. Since then, evidence of the enormous economic consequences of these diseases, which extend far beyond the costs of care, has grown. These figures, such as a billion dollars lost each year because of lymphatic filariasis in India alone, have great persuasive power when priorities are set and funds are allocated nationally and internationally.

The other side of the economic argument has also received attention in recent years. Economists have welcomed rapid impact interventions as bringing exceptionally high returns on investment. They are cost-effective, improve health, increase worker productivity, improve educational outcomes and expand the domestic pool of resources. All of these factors contribute in well-documented ways to economic growth.

Persuasive arguments have come from additional lines of evidence. Research continues to reveal the intricate damage caused by these diseases. The subtle morbidity they cause – the excruciating pain, fatigue and impaired cognitive function – are now better understood and appreciated.

These effects have an immediate and profound impact on agricultural productivity and educational outcomes. Such findings make these diseases important for other development sectors, including agriculture and education.

Research has also demonstrated a surprising number of ancillary benefits of preventive chemotherapy: improved micronutrient uptake and nutritional status, better cognitive performance and improved childhood growth. Moreover, mass campaigns have completely eliminated some dreaded parasitic skin diseases. This unexpected benefit has increased public perceptions that these drugs are beneficial. It has also made populations receptive to subsequent campaigns.

With these various arguments in their favour, the neglected tropical diseases have arrived. They have moved into the mainstream of development thinking.

Having done so, control of these diseases now faces at least two of the most pressing problems confronting public health today. These
are the management of partnerships and the strengthening of health system capacity.

When strategies for the integrated delivery of interventions were discussed at the second Berlin meeting, a question was raised: will this not increase the burden on the district health system?

The answer was straightforward: the burden is already there. In some districts in Africa, as many as 15 different agencies are implementing programmes, without coordination, and sometimes using different drugs and treatment regimens.

This is a problem that must be addressed. Part of the responsibility rests with donors and implementing agencies. There has been much recent debate about effective aid, about the new architecture for public health. We must never forget: architecture rests on a foundation.

Decades of experience have taught us that activities undertaken by external agencies must be firmly rooted in national capacities and closely aligned with national priorities. This is the only sure route to sustainability.

Let me repeat: our mandate must come from ministries of health. It is good to have so many health ministers present in this room and to know that these diseases are receiving priority.

WHO also has an important responsibility. In our role as the leading technical authority on health, we can set the control strategies and define best technical practices. This is one way to better align the work of partners with international standards, strategies and recommended practices.

Evidence has great strategic value. Last year’s manual on integrated preventive chemotherapy is strongly evidence-based. It also gives national authorities a flexible menu of options, so that recommended drug regimens can be adapted to local capacities and epidemiological conditions. This is important. WHO can propose strategies and best practices, but should not impose them. Countries must be the command centre, fully in charge of what is happening within their borders.

As a second major challenge, control strategies must address the weaknesses, in nearly all developing countries, of delivery systems. Here is the central dilemma we face. Multiple partnerships have formed to deliver specific health outcomes.

The ability to deliver these outcomes depends on a functioning health system. Yet the strengthening of health systems is seldom the core purpose of these partnerships.

If we want improved health to work as a poverty-reduction strategy, we must deliver interventions to the poor. Here is where we frequently fail. Here is where greater innovation is needed. All the donated drugs in the world will not do us any good in the absence of systems for their delivery to those in need.

I look to this group of diseases to pave the way forward on this important issue. I know you have found ways to use existing delivery systems, such as schools, in efficient and cost-effective ways.

We know, too, that immunization programmes – which often achieve the highest coverage of hard-to-reach populations – are beginning to distribute packages of interventions, including bednets for malaria and deworming tablets for parasitic diseases.

The Berlin meetings have addressed this issue and have pointed to the importance of demand-led initiatives, in which communities take charge, in line with their perceived needs and priorities. Here, this group of diseases has yet another advantage: they are universally dreaded by populations.

Prevention and care are highly desired. Imagine the impact when a young woman with leprosy is told she can be fully cured, can marry, have children and will not infect others. Just imagine the impact.

Many interventions bring rapid physical relief, which stimulates acceptance and further demand, even when the disease itself is poorly understood. It is this bottom-up demand that ultimately puts pressure on the political and health systems to deliver in sustainable ways, in line with population needs.

We have seen this happen with onchocerciasis, which began as one of the most vertical programmes imaginable: helicopters dropping insecticides out of the sky!

When the disease burden was sufficiently diminished, onchocerciasis control became a horizontal programme, operating much in line with the principles of primary health care.

Ultimately, this programme gave us the community-directed distribution strategy, another important innovation that has been extended to other diseases.

Although we do not yet have solid evidence, it is logical to assume that mass delivery of high-quality drugs will spur improvements in at least some parts of the health system. I am thinking here of drug procurement, storage and transportation systems, of record keeping, inventories, evaluation and monitoring. There are certainly other areas.

I know that several of these issues will be addressed when the working groups meet. I look forward to your deliberations.

In conclusion, I want to return to my initial statement. This meeting is a turning point in the
long and notorious history of some of humanity’s oldest diseases. Historically, these diseases – so strongly tied to poverty – have gradually vanished from large parts of the world as incomes increased and standards of living and hygiene improved.

Today, we no longer have to wait for these diseases to gradually disappear. We no longer have to wait for gradual improvements in housing, water supply, sanitation and other basic infrastructures to take place. We can act right now to deliberately push these diseases back.

This is why this moment in history is different. The relationship between these diseases and poverty works two ways. We can turn the conventional formula around. We have the tools to control these diseases and, in so doing, we can reduce poverty.

Populations left behind by socioeconomic progress are in dire need of safe water and adequate sanitation, better access to health services, more opportunities for education and improved nutrition. However, they also need to be freed from the burden of disabling and debilitating infectious diseases.

For the first time, we have a head start on these ancient companions of poverty. For the first time, more than one billion people left behind by socioeconomic progress have a chance to catch up.

I believe this is our shared ambition.

Keynote address by distinguished guests

His Excellency Mr Blaise Compaoré, President of Burkina Faso

WHO has led an historical challenge by convening the first meeting of global partners dedicated to neglected tropical diseases, among which I should include meningitis as far as Burkina Faso is concerned. The fact that this important meeting has been convened in this beautiful city of Geneva, that as early as the nineteenth century battles were won against devastating scourges such as plague and smallpox, gives hope to African countries that they will be able to lay the foundations for sustainable human development.

Madam Director-General, your invitation to southern African countries reflects the attention that you give to this continent on your agenda. Burkina Faso and its 14 million inhabitants strive to preserve and develop its human capital in order to better consolidate the foundations of its economic production; in this respect, disease control plays a strategic role in governmental action, as demonstrated by the implementation of a National Health Development Plan for 2001–2010 that yielded significant results three years before the end of that programme. This is why I welcome the creation of a Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (the Global Fund) and to support national efforts and those of many partners who have already been successful in combating these scourges.

Greater efforts and even more dedicated commitment on the part of the international community are still needed to overcome the neglected diseases that are rampant in the tropics and that affect the poorest of the poor who have limited access to health care. These diseases have a limited geographical scope and are characterized by the fact that effective treatments exist that are not within the reach of the vulnerable populations.
The emergence of certain epidemics in these areas compounds those already identified by WHO and, in this regard, I wholeheartedly support the creation of a fund to fight neglected tropical diseases similar to the Global Fund that would ensure better organization of control activities and more effective research.

Advocacy by WHO for these tropical diseases gives hope for treating lymphatic filariasis, intestinal parasitic diseases and leprosy. Such advocacy has already led to the eradication of onchocerciasis, the decreased prevalence of trachoma and the availability of treatment for human trypanosomiasis. For sustainable control to be even more relevant it is necessary to develop new therapies and make them available at low cost.

The high-quality cooperation between African states and pharmaceutical companies, along with WHO and the networks of partners within alliances, must extend to control of leishmaniasis, Buruli ulcer and meningococcal meningitis in order to become more effective. At a time when several African countries have to deal with serious, severe epidemics, WHO has asked for my sponsorship in developing an anti-meningococcal vaccine against meningococcus.

I reaffirm my commitment to advocating access to this vaccine for the populations of the Sahel states. Widespread delivery of this vaccine would contribute to arresting the harmful affects of these recurring epidemics that imperil the health of our populations and reduce their productivity.

The international meeting on dracunculiasis eradication, held in Ouagadougou on 27–29 March 2007, revealed that the number of dracunculiasis cases fell from close to 1 million in 1989 to a mere 3600 at the end of 2006 in eight African countries. In Burkina Faso only 5 cases were recorded in 2006, compared with 12 000 cases in 1992. These achievements were made possible thanks to the leadership of the organization where you are now at the helm; and thanks also to the generosity and commitment of many private partners such as The Carter Center that I warmly commend.

In recent years, Burkina Faso launched a campaign of mass drug administration against lymphatic filariasis involving more than 10 million people, which made possible interruption of active transmission of the disease. Thanks to the unwavering support of our partners, close to six million children aged under 15 years were treated against schistosomiasis within three years. I would like to take this opportunity to express my deepest gratitude to WHO and partner networks for your effective cooperation. Without such cooperation we could never have achieved such encouraging results.

In order to win a decisive battle against these diseases, African states need to come together and to better organize and coordinate their activities in order to devise strategies to control these scourges. To this end, an integrated project of programmes to control neglected disease was launched in Burkina Faso on 12 April 2006. Its goal is to intensify and coordinate efforts to control lymphatic filariasis, schistosomiasis, onchocerciasis, trachoma and helminth infections. We would like to share this model of integration with all the countries concerned in order to foster and exchange experiences.

I wish to join hands with others in congratulating Your Excellency Madam Margaret Chan on your appointment as the WHO Director-General. I believe that you will serve this important institution with dedication.

I am most grateful for the honour extended to me to offer a keynote address. On behalf of the Government and the people of the United Republic of Tanzania, and on my own behalf, I wish to express my profound appreciation to you and the entire staff of WHO for the initiative of convening this important meeting to share views on effective measures to curb these diseases.

As we are all aware, these diseases have devastating effects on the lives of many people in the developing countries, particularly in sub-Saharan Africa. It is an extremely important meeting, and I believe it will be seen as
a demonstration of solidarity among our governments and various agencies as well as organizations that work together to relieve the people, particularly the poor people, from the unnecessary burden of these diverse tropical diseases.

I am pleased to observe that WHO continues to have a special concern for strengthening the delivery of health-care services to poor people, especially in Africa. It recognizes the urgent need to reach out to marginalized populations, particularly women, girls and young children, who are at a high risk from diseases.

I would say with confidence that had the founding father of our nation, the late Mwalimu Julius Nyerere, still been with us today, he would have endorsed and supported without hesitation the efforts by WHO to develop effective policies for the sustainable delivery of health-care services to the people.

Let me also take this opportunity to reassure WHO of the full support of the Government of the United Republic of Tanzania, and my personal support, for all these noble efforts. I believe that other countries in Africa should not only render their full support but also join in these efforts to achieve sustainable health service delivery.

The opportunity to address this distinguished gathering here today has given me the chance not only to reflect on some thoughts about the themes that will be discussed at this meeting but also to share with you the experience of Tanzania in combating these so-called neglected diseases. I believe you all know that these diseases have consequences that impact negatively on the efforts of a developing country such as Tanzania to achieve socioeconomic advancement.

The five themes are the so-called neglected tropical diseases; their impact on national development; their unacceptable persistence; the delivery of accessible health care to people in need; and the importance of partnership for the provision of accessible health care.

**Neglected tropical diseases**

I find it quite commendable that WHO, in August 2005, established in its structure the Department of Control of Neglected Tropical Diseases. The department’s title is clear testimony to its mission. This move has elevated the status of the fight against neglected tropical diseases.

The 13 common chronic diseases debilitate, deform, blind and even kill many people in the endemic areas. These are serious diseases that inflict and weigh their heavy and corrosive burden on the lives of the affected individuals and communities as well as countries in most parts of Africa. They affect the poorest segment of the population, and their greatest impact is in the way they exacerbate poverty, stigmatize individuals and inhibit communities from being able to care for themselves and their families.

Why then are these diseases defined as neglected? Could the answer lie in the fact that, unlike HIV/AIDS, malaria and tuberculosis, they pose little threat to the affluent countries, as they do not readily cross the porous borders of our globalized world?

These diseases are not neglected in any way by the developing countries. We, in Tanzania, for example have recognized, since the dawn of independence, that health status and health service delivery are the core of socioeconomic development. We have waged a protracted war against all diseases that are regarded as a hindrance to development, alongside poverty and ignorance. The most common neglected diseases in our country are lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis, trachoma and human African trypanosomiasis.

Lymphatic filariasis is endemic in all regions of the Tanzanian mainland and in Zanzibar, while onchocerciasis, active trachoma and blinding trachoma are endemic in about 50 districts on the Tanzanian mainland. However, schistosomiasis and soil-transmitted helminthiasis are endemic country-wide, with high prevalence of schistosomiasis in the Lake zone, the coastal areas and in Zanzibar, especially on Pemba Island. After independence, attempts to control some of these diseases were carried out in a completely vertical manner. Although some successes were registered, the gains could not be sustained. This was followed by a slightly more comprehensive approach of incorporating the programmes into the health system, mainly following the health sector reforms. In this regard there has been tremendous progress, although duplication of activities has been evident. These programmes have formed part of the poverty eradication efforts towards implementation of the Millennium Development Goals.

Poverty reduction efforts and social and economic development will remain constrained if prevalence of these diseases continues. Some of the successes include lymphatic filariasis control programmes on the Tanzanian mainland and in Zanzibar. On the mainland the programme is in its sixth year, while the Zanzibar programme is in its fifth year. Data from both areas have shown reduction in the prevalence of the disease. In fact, some areas in Zanzibar have recorded zero prevalence. Another notable success is that 8 000 000 of the 12.5 million at risk of trachoma have been treated with Zithromax® (azithromycin). On Zanzibar, schistosomiasis
control programmes have recorded reductions in prevalence from 64.5% to 8.1% in schoolchildren.

Given the successes demonstrated by programmes that have been integrated into the health system, there is a need to focus on integration of the individual programmes. This move will avoid duplication and enhance sustainability.

The support provided by WHO, its partners, nongovernmental organizations and various constituencies has put in place several initiatives to control individual neglected diseases effectively, e.g. lymphatic filariasis, onchocerciasis, schistosomiasis and trachoma. To help improve efforts to control neglected tropical diseases, and in collaboration with governments and partners, WHO organized an international workshop in Berlin, Germany, in late 2003 that led to a broad consensus on a framework for action against neglected diseases in vulnerable populations. A key component of this framework is the establishment of integrated approaches where geographical overlap exists between diseases and where appropriate interventions are available.

With public and private partnerships, the integrated control of neglected tropical diseases can be implemented at very marginal costs per person treated. Therefore, by integrating the control of bilharziasis, helminthiasis, elephantiasis, river blindness and trachoma, the pay-off is enormous.

I am happy to observe that other countries in Africa have designed and implemented various programmes to combat these diseases. I believe you already know that Burkina Faso has achieved the target of providing access to essential medicines to over 75% of school-age children who are at risk from schistosomiasis and soil-transmitted helminthiasis.

I wish to take this opportunity to congratulate His Excellency the President, the Government and the people of Burkina Faso for this achievement, which has made their country the first one in our continent to attain this target set by the World Health Assembly.

In the Democratic Republic of the Congo, health workers have managed to halt the progression of African sleeping sickness. Let me also salute His Excellency the President, the Government and the people of the Democratic Republic of the Congo for their success against this deadly disease. I should also commend, in general, the good work of many health professionals who, between 1975 and 2002, laboured to implement successfully the Onchocerciasis Control Programme in several countries in West Africa. The dracunculiasis control programme has brought the disease to the threshold of eradication. Guinea-worm infection, which causes dracunculiasis, has now as few as 20 000 cases remaining, which are mainly found among the rural populations of Africa. Many people, beyond Africa, may not realize that dracunculiasis is so near to eradication. When this goal is achieved in the near future, dracunculiasis will be the second scourge to be eradicated after smallpox.

It is not possible to mention all the successes made by the many different countries against these so-called neglected tropical diseases. All in all, let me congratulate the efforts made to combat these diseases.

The valuable support of development partners and donors is both welcome and appreciated in enhancing and strengthening our efforts in waging a more successful war against these diseases.

**Impact of neglected tropical diseases on national development**

Health has a critical contribution to the social and economic well-being of individuals and communities. A number of studies have unequivocally established that the 13 neglected diseases are of major public health significance. Their debilitating nature contributes to an ongoing vicious cycle of poverty, stigma and disability, resulting in many millions being unable to work and participate in community life. A growing body of compelling evidence shows that worker productivity, wages and profits generated by economic activities steadily increase with enhanced health interventions and delivery to the workforce. It goes without saying, therefore, that freeing people from the debilitating effects of these diseases goes a long way towards increasing socioeconomic development.

In the United Republic of Tanzania, as in many other developing countries, the mainstay of the economy is agriculture, which provides a livelihood for the majority of the population. Women in the rural areas work hard, and for long hours, manage households and take care of children and families, in general. Women, therefore, make an enormous contribution to the economic and social welfare of the nation. Ironically, it is children, women and those in areas without any access to the health-care system who are most vulnerable to the deleterious effects of neglected tropical diseases. Our government has been taking the necessary measures to curb the burden of diseases on women, children and other vulnerable groups. Relieving women from the scourge of neglected
tropical diseases, therefore, is investing wisely in the development and future of our nation.

We know that improvements in the cognitive development, educational performance and school attendance of children are a direct response to accessible health interventions. The future of a nation lies with its children. Every country strives to give its children the best possible start in life and to protect them from diseases through the provision of health care. Appropriate health-care delivery, to children in particular, represents security for the future and prosperity of a country.

Children, including those born today, are the ones who will take our society into the future. They will take forward what the old generation has started, and go on to assume control of the affairs and institutions of the nation. Abraham Lincoln said many years ago that our children will carry on what we have started; that they will assume control of our cities, states and nations, and that the fate of humanity is in their hands. It is our duty and responsibility to ensure, therefore, that our children have the best chance of success in life.

The unacceptable persistence of neglected tropical diseases

Why should I draw your attention to what I call the unacceptable persistence of these diseases? These diseases are now unacceptable because public health tools exist to bring them under control and, in some cases, to eliminate them altogether. In theory, 1000 million people should no longer have to suffer from neglected tropical diseases.

Advances in knowledge have now enabled us to have an insight into the population biology of the infectious agents and to understand the epidemiology of the diseases. We know the distribution of these diseases and the factors that put people at risk of infections.

Also readily available are safety tested and effective drugs for use in the control of the diseases in the community. These drugs can be given as single oral doses, and they are also effective against a diverse range of diseases. I understand, for instance, that yaws, which is a disfiguring disease, can simply be cured by a single injection of penicillin.

I wish to acknowledge here, however, that the light against these diseases would have been even more daunting without the generosity of our partners from the pharmaceutical industry, development agencies and donor countries. They have donated and assisted in the procurement, distribution and delivery of the drugs.

It is commendable that the WHO Department of Control of Neglected Tropical Diseases has devised and introduced preventive chemotherapy as a new strategy for drug use in the community that targets lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma. I understand that this strategy is a drug-based intervention as opposed to a disease-based one, and it is my hope that it will be effective enough as we look forward to its implementation.

It is also a welcome development to know that this department has also devised, and introduced, a new public health strategy in the manner of innovative and intensified disease management. It is gratifying to know that this approach aims at controlling or eliminating diseases such as Buruli ulcer, Chagas disease, leishmaniasis and trypanosomiasis.

Although the management of this assemblage of diseases remains difficult, it promises to bring needed relief. The good thing is that the innovative component of this strategy is the development of tools to simplify disease management and facilitate treatment as part of primary health care. We welcome the short-term goal of reducing the number of cases and the longer-term objective of securing sustainable control, which should lead to elimination of these diseases.

As I have pointed out, people no longer have to suffer from the neglected diseases. Yet so many people still continue to endure the effects of these diseases. I believe the explanation for this is that there is inadequate health-care delivery. Health-care services do not match the current demand for them.

Delivery of accessible health care to people in need

As you are all aware, many millions of people in Africa live where health-care services are inaccessible. Those who are so urgently in need of public health interventions are also the ones who subsist in the grip of poverty in the rural areas and congested slums of urban centres and shanty towns.

I am happy to observe that many countries in Africa are giving due priority to the issue of accessibility and delivery of health-care services. Governments in these countries have formulated national health policies and initiated health reforms that focus on access to essential drugs and other treatment measures.

The task before the governments is enormous, while the resources at their disposal are inadequate. This is a challenge that calls for action. Limited resources and minimal infrastructure not only make it harder to control the diseases but also hinder the realization of
First Global Partners’ meeting on NTDs

I am pleased to take this opportunity to commend the increasing attention to the neglected tropical diseases, and what that attention will mean to the millions of people who suffer from them. My colleagues at The Carter Center and I have focused our efforts on one of the most neglected of diseases, dracunculiasis (guinea-worm disease), for the past 20 years, and on onchocerciasis, schistosomiasis, lymphatic filariasis and trachoma for more than a decade.

Apart from being neglected, these diseases are accessible delivery of health care to people in need.

I do believe, however, that through addressing neglected tropical diseases in a cohesive manner, and integrating this into our primary health-care systems, we have an opportunity to improve the overall delivery of health care. As these diseases also tend to affect the poorest in our populations, it is a great platform from which to address the fight against poverty. I cannot overemphasize, however, that for one to attain the maximum impact, these interventions must be carried out through robust health systems.

Partnerships for the provision of accessible health care

Emphasis placed by this meeting on the importance of partnership in the delivery of health-care services is both relevant and timely. Partnerships between governments and institutions in the private and charitable sectors are proving quite indispensable in health-care delivery, regardless of gross national income per capita of a country. It is said that even in developed countries, governments can no longer manage to support their health service entirely from the treasury.

It is highly appreciated that WHO, its partners, nongovernmental organizations and other entities have put in place several initiatives on disease control in the spirit of a framework for action on neglected tropical diseases for vulnerable populations.

I would like, therefore, to urge all partners to work even harder with the governments of countries in Africa where neglected diseases are endemic, in noble efforts to control, eliminate and eradicate this unacceptable human suffering.

I wish to take this opportunity to call upon WHO to employ all its experience in advocacy to convince more partners to support this noble cause. Now that we have powerful technologies for effectively combating diseases, we need to promote and strengthen partnerships by increasing health-care delivery to people in need. We should not give people opportunities to accuse us of negligence in fighting this scourge. Efforts to control the neglected diseases will no doubt make a significant contribution to the attainment of the Millennium Development Goals.

I am looking forward to a time when our governments in Africa will report that blindness from trachoma is no longer a public health problem; that lymphatic filariasis has now been eliminated; that hookworm no more complicates pregnancies and the survival prospects of newborn children; that schistosomiasis no longer weakens our school-age children; and that deformities and stigma associated with leprosy have been consigned to history.

But what would be more interesting to look forward is the announcement by WHO that it has decommissioned its Department of Control of Neglected Tropical Diseases because its mandated work has been done.

Let me conclude my remarks by thanking you most sincerely Dr Chan, Director-General of WHO, for inviting me to Geneva to call upon the agencies of United Nations Member countries of the G8, the Commission for Africa and many other partners who are involved in the control of neglected tropical diseases to continue with, and step up, this commendable effort.

It is my earnest hope that all the partners will continue to work even more closely with WHO on endeavours to overcome the human suffering perpetuated by neglected tropical diseases. These diseases should no longer be neglected.

I thank you all for your attention.

Letter from former US President Jimmy Carter

To the First WHO Global Partners’ Meeting on Neglected Tropical Diseases

I am pleased to take this opportunity to commend the increasing attention to the neglected tropical diseases, and what that attention will mean to the millions of people who suffer from them.

My colleagues at The Carter Center and I have focused our efforts on one of the most neglected of diseases, dracunculiasis (guinea-worm disease), for the past 20 years, and on onchocerciasis, schistosomiasis, lymphatic filariasis and trachoma for more than a decade. Apart from being neglected, these diseases are
Mrs Kumiko Hashimoto, philanthropist, wife of former Japanese Prime Minister, the late Ryutaro Hashimoto, Japan

Geneva in April: the mountains of the Alps glisten in the distance, fresh new leaves are beginning to emerge and flowers in every colour reflect in the lake. Arriving in this beautiful international city in springtime, the season when new life is bursting, I can feel that a new wind is sweeping through and that history will be changed. Seeing the cherry blossoms in full bloom in the lush green garden of WHO also brings back the fond memories I have of the day I visited Geneva with my late husband.

I would like to express my deep gratitude to Dr Margaret Chan for inviting me to this important meeting today. I would also like to take this opportunity to express my heartfelt congratulations to Dr Chan for her selection as the General-Director of WHO. I firmly believe that under Dr Chan’s leadership, WHO will make a significant contribution to the health of nations and people around the world. As a fellow female from Asia, I am very pleased by this splendid decision.

On behalf of my late husband Ryutaro Hashimoto, I would like to express my gratitude and congratulations for holding this outstanding partnership meeting. I am greatly honoured to be able to participate in this important forum, where people with a strong will and sense of mission towards the fight against neglected tropical parasitic diseases have come together from all over the world to discuss and understand each other in order to deepen their partnership, as well as to confirm that they are all heading towards the same goal. It makes me realize that the seed sown by my husband has sprouted and is growing and thriving.

As a politician, my husband worked very passionately in the area of health. As the Prime Minister of Japan, my husband took up the issue of parasitic disease control at the Denver Summit in 1997. This was not for political posturing or manoeuvring: he viewed parasitic disease control as one of the challenges of humanity. He hoped that Japan would live up to its role in fundamental areas over the course of the coming years, and, if possible, he hoped that developed nations could work together and start a global movement for parasitic disease control.

This was the result of the accumulation of many experiences beginning from his early childhood days. When my husband was little, he saw the passion with which his father, then Minister of...
Health and Welfare, committed himself to the eradication of malaria, which was prevalent in Japan at the time. After his father passed away he aspired to become a politician, and decided to commit his life to the area of health. When he was the Minister of Health and Welfare, he contracted amoebic dysentery in Papua New Guinea in 1969 and came down with dengue fever in Myanmar in 1970. It seemed that his own experience made him realize that tropical diseases were a critical health issue. The Hashimoto Initiative was proposed at the Denver Summit based on these experiences.

In March 2000, my husband gave a speech at the G8 follow-up International Symposium in Kobe, in which he said, “3.5 billion people are suffering from soil-transmitted nematodes around the world. Despite this fact, the matter is drawing little attention from the public, the media and politicians. This is all the more why we must stress the importance of parasitic control. In this way, we would hope to contribute to humankind”. Indeed, the importance of tropical parasitic control was not recognized at the time.

And now a decade later, in 2007, I am deeply moved by the fact that a global plan has been developed for tropical parasitic or neglected disease control, with the efforts of WHO, governments, experts and partners; and, furthermore, that an international meeting like this one, which brings together those important players, is being held. I am sure my husband is also expressing his happiness in heaven. Just like the cherry blossoms in full bloom here at WHO headquarters, I believe that today the wishes my husband held when he proposed parasitic control as an agenda item of the G8 are blossoming.

Now let me say a few words about Japan’s efforts. The Government of Japan, particularly the Ministry of Health, Labour and Welfare, the Ministry of Foreign Affairs, the Japan International Cooperation Agency and the Nippon Foundation have maintained and continued to implement the initiative of my late husband as a socially and practically significant measure. For example, in Ghana, Kenya and Thailand, Japan implemented parasitic control measures based on school health – the so-called CIPAC Project – in cooperation with the respective governments, and they have been very fruitful. I very much hope that the initiative will continue to make further advances.

Tropical parasitic diseases continue to place an enormous burden on disadvantaged and vulnerable groups. My heart aches knowing that this is a significant problem for the people of sub-Saharan Africa, Asia, Latin America and the Caribbean, especially for women who occupy a central role in their households. We women must rise up and do our part for women in vulnerable situations. I understand that Dr Chan has made Africa her priority and women her focus. For my part, I would like to cooperate with the partnership, not only on behalf of the Hashimoto Initiative of Japan but also in support of the partnership, as one female.

The times are changing such that today, various partners are forming partnerships and joining hands towards a single objective. I feel honoured to be able to work together and cooperate with the various partners in this room. In order for the partnership to function well, I believe that WHO has a critical role to play as an entity that provides technical guidance and advice based on scientific grounds. I have great expectations for WHO under Dr Margaret Chan.

Last but not least, I would like to commend from my heart the unflagging efforts and passion of the people in this room, who share my husband’s dream of eradicating parasitic diseases. I would like to join you in extending our warm wishes, like the cherry blossoms in full bloom, as well as a helping hand that will assuredly change the unfortunate reality, to our friends who are still suffering from these diseases and with whom we share this planet.

May the neglected people be blessed with hope and health.
I was born in Cameroon 26 years ago. When I was a schoolboy, my teacher would tell us, as all teachers did throughout Cameroon, the story of sleeping sickness. In the 1930s, this dreadful disease devastated my country and killed men, women and children indiscriminately. As a result, villages were abandoned. At the time it was decided to mobilize all possible means to eradicate this disease. The first African school for specialized laboratory technicians opened in Ayos not far from where I lived. The huge efforts and many years of control made it possible for these various teams to reach their goal and, thus, the disease completely disappeared from Cameroon and Africa in 1962.

This inspiring story, with which the name of my country is closely associated, is still taught in schools. It is a story that teaches all Cameroonian children that it is possible to win, however formidable, one’s adversary, if only you devote all of your energy to that goal. It is also my story, the story of a little boy who dreamed of becoming a great football player; a little boy who never forgot the teachings of these thousands of nurses who won the most wonderful battle of all, the battle of life. Now I am fortunate enough to be applauded in stadiums throughout the world. I do not forget and will never forget the children of Africa in whose eyes today there is a glimmer of hope; and that is why I offer part of my energy to all of those living in these villages who, too often, suffer from indifference.

I am not a doctor, but every time I go home I see these dreadful diseases, so I know what they are. I am familiar with Noma, Buruli ulcer and all the other diseases that we are dealing with today because they have all ravished our villages.

It is true, as I said, I am particularly interested in sleeping sickness, because it has reappeared in our countries. I would like, sincerely, to join forces with you to combat against negligence, for there is nothing worse than being forgotten, wherever you live in the world; and that is why, Madam Director-General, I feel greatly honoured to bring my contribution to WHO, because you are the spearhead of this commendable initiative.

Every week, on the football field what I do is to score goals and to give some pleasure and joy to those watching the game. Today, I am here as a fan, so to speak, to lend my support to your work on behalf of all the people of Africa and all continents. I call upon you, Madam Director-General to bring relief to our brothers and to give hope to all children in the world: hope that they can live in a world free of neglected diseases. I would like this effort to be undertaken here and now and to be pursued in the long term. On their behalf, as well, I urge all the partners assembled here today to continue to lend their assistance and intensify this assistance. I offer you, Madam Director-General, my help with great humility but also with great determination.
"This meeting is a turning point in the long and notorious history of some of humanity’s oldest diseases. Historically, these diseases – so strongly tied to poverty – have gradually vanished from large parts of the world as incomes increased and standards of living and hygiene improved.

Today, we no longer have to wait for these diseases to gradually disappear. We no longer have to wait for gradual improvements in housing, water supply, sanitation and other basic infrastructures to take place. We can act right now to deliberately push these diseases back. [...] For the first time, more than one billion people left behind by socioeconomic progress have a chance to catch up."

Dr Margaret Chan
Director-General, World Health Organization
Since WHO was established in 1949, its Member States have met regularly at the World Health Assembly to evaluate the state of world health and set the world’s health agenda. The following resolutions have direct bearing of the assemblage of health problems now recognized as neglected tropical diseases.

<table>
<thead>
<tr>
<th>Resolution</th>
<th>Year</th>
<th>Goal and target date</th>
<th>Public health problem</th>
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<tbody>
<tr>
<td>WHA 31.58</td>
<td>1978</td>
<td>To implement programmes for integrated control in order to interrupt transmission as early as possible</td>
<td>Endemic treponematoses</td>
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<tr>
<td>WHA 42.31</td>
<td>1989</td>
<td>To build capacity for planning and implementation of operations to control disease vectors and nuisance pests; to broaden collaborative efforts between WHO and FAO in promoting the effective and safe use of public health pesticides</td>
<td>Vector-borne disease prevention and control</td>
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<tr>
<td>WHA 44.5</td>
<td>1991</td>
<td>To eradicate dracunculiasis by 1995</td>
<td>Dracunculiasis</td>
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<tr>
<td>WHA 44.9</td>
<td>1991</td>
<td>To eliminate leprosy as a public health problem (prevalence below 1/10 000 population at national level)</td>
<td>Leprosy</td>
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<tr>
<td>WHA 47.32</td>
<td>1994</td>
<td>To control onchocerciasis through distribution of ivermectin</td>
<td>Onchocerciasis</td>
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<tr>
<td>WHA 50.29</td>
<td>1997</td>
<td>To eliminate lymphatic filariasis as a public health problem</td>
<td>Lymphatic filariasis</td>
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<tr>
<td>WHA 51.11</td>
<td>1998</td>
<td>To collaborate with the WHO alliance for the global elimination of blinding trachoma by 2020 as a public health problem</td>
<td>Blinding trachoma</td>
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<td>WHA 54.19</td>
<td>2001</td>
<td>To reach at least 75% of school-age children at risk of schistosomiasis and soil-transmitted helminthiasis with anthelminthic treatment by 2010</td>
<td>Schistosomiasis and soil-transmitted helminthiasis</td>
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<tr>
<td>WHA 55.17</td>
<td>2002</td>
<td>To strengthen prevention and control of dengue through implementation of the global strategy</td>
<td>Dengue fever and dengue haemorrhagic fever</td>
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<tr>
<td>WHA 56.7</td>
<td>2003</td>
<td>To support the Organization of African Unity’s initiative to eradicate tsetse flies; to eliminate human African trypanosomiasis as a public health problem</td>
<td>Human African trypanosomiasis</td>
</tr>
<tr>
<td>WHA 57.1</td>
<td>2004</td>
<td>To support the Global Buruli ulcer initiative</td>
<td>Buruli ulcer</td>
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<tr>
<td>WHA 57.2</td>
<td>2004</td>
<td>To intensify control of human African trypanosomiasis</td>
<td>Human African trypanosomiasis</td>
</tr>
<tr>
<td>WHA 57.9</td>
<td>2004</td>
<td>To complete eradication of dracunculiasis by 2009</td>
<td>Dracunculiasis</td>
</tr>
<tr>
<td>WHA 59.25</td>
<td>2006</td>
<td>To prevent avoidable blindness and visual impairment</td>
<td>Onchocerciasis, trachoma</td>
</tr>
<tr>
<td>WHA 60</td>
<td>2007</td>
<td>To strengthen control of leishmaniasis</td>
<td>Leishmaniasis</td>
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</table>
The fundamental right to health and the right to medical care for every patient if a disease can be easily eradicated are responsibilities we must not neglect. Patients have the right to integrity; for that they have to be partners in health services and be empowered in primary health-care systems and shown how to integrate vertical as well as horizontal services, for example, vector control through primary health care.

This meeting demonstrates that neglect transforms attention and fear into compassion, and that action will preserve the human dignity of the most poor, neglected people of the world.

**Austria, Dr Helmut Friza, Minister Plenipotentiary (Public Health), Permanent Mission of Austria to the United Nations Office in Geneva and the Specialized Agencies in Switzerland**

Fighting neglected tropical diseases is a priority for France’s strategy of cooperation in the health field, and these diseases are also part of our development agenda. They mainly affect poor rural populations who are disadvantaged in many ways. Indeed, they do not receive donations from any of the large international political funds. Poor people in rural communities have little access to health care systems and draw less attention from the international community.

The fact that these diseases perpetuate discrimination makes it imperative for us to act with determination in a way that is coordinated and harmonized. We need to bring together this accord through the following stakeholders. Researchers, so they can develop effective treatments that are easy to use. The role of PDPs such as DNDI or the Special Programme for Research and Training in Tropical Diseases play an important role in this respect. We also need the support of the pharmaceutical industry. Their partnership is crucial to allow access to diagnostic tools and high-quality care that is affordable. I would like to commend the signing in October 2006 of a new partnership between WHO and sanofi-aventis in 2006–2011 for a value of 20 million euros.

We also need the support of health-care workers so that they can help patients to comply with treatment. I would like to applaud the role of civil society and nongovernmental organizations for their significant contribution in the field. Of course, we also need the support of endemic countries in mainstreaming programmes for prevention and control of these diseases in their national health policies and in taking ownership of these strategies. Beyond that, we need the support of the entire international community for them to give priority to neglected tropical diseases.

The funding of programmes for onchocerciasis control represents more than US$ 8 million; control of trypanosomiasis via a specific project for central Africa with the Institut Pasteur represents close to US$ 2 million. Funding by the French Ministry of Foreign Affairs and Development Agency for developing new drugs to control neglected tropical diseases amounts to close to US$ 10 million. We are also working with partners to develop new drugs and vaccines alongside various manufacturers such as Pfizer Cruz in Brazil.

**France, Ambassador Jean Maurice Ripert, Permanent Mission of France to the United Nations Office in Geneva and other International Organizations in Switzerland**

We, as Germany, would like to congratulate WHO on drawing the attention of the international public health community to the needs of preventing, diagnosing and treating neglected diseases in neglected populations. This is a fight that underlines, in a particular way, a human rights based approach to the provision of health care. It is a fight that will contribute to greater equity in health between rich and poor, between men and women and between generations. We greatly appreciate, therefore, the efforts of the secretariat to strengthen the structures here at WHO, to enable it to provide technical support and advice to Member States seeking guidance while scaling up and improving their respective programmes.

We would like to thank you very much for your kind words regarding the meetings in Berlin. It has been an honour to work with the teams of
the Department of Control of Neglected Diseases and the Special Programme for Research and Training in Tropical Diseases; and, of course, with the many distinguished research and training institutions throughout the world as well as private sector representatives in preparing the technical consultation meetings. It is a highly rewarding experience for all partners to see the dynamic of this process and how it has been accelerating with relatively little initial support that was needed to spark it off. The fight against neglected tropical diseases is an important contribution to poverty alleviation, which is one of the major commitments in Germany’s Millennium Development Goals action programme 2015 and which is also expressed in the European Commission Paper on Health and Poverty Alleviation from the year 2002.

Germany’s main priority in development cooperation in health has been the overall strengthening of health systems and improvement of their sustainability through addressing high-quality management; sustainable health-care financing; and institutional capacity building that includes strengthening research and academic institutions through university partnerships. Improving access to medicines for all in a sustainable manner is a particular challenge. In its capacity as Presidency of the European Union, Germany recently organized a meeting of the 27 European Union member states in Brussels, with representatives of the pharmaceutical industry and with nongovernmental and faith-based organizations. The aim of this meeting was to decide on the Union’s input into the intergovernmental working group on public health innovation and intellectual property. One of the paths being followed in this context is now the support to local production of essential generic drugs in developing countries. This approach will make drugs financially more accessible on the one hand but also contribute to overall economic development on the other. The partners in this endeavour are, therefore, the United Nations Industrial Development Organization and the United Nations Conference on Trade and Development. Nongovernmental and other organizations are partners in the inter-country training programmes for the pharmaceutical sector.

Currently, the Democratic Republic of the Congo, Kenya and the United Republic of Tanzania are being supported by bilateral programmes; and a number of intercountry feasibility surveys are under way to see which other countries are eligible for support. These programmes now include Bangladesh, Ethiopia, Lesotho, Senegal and Thailand. In this initial stage, most of the production is focused on essential drugs needed for HIV/AIDS and malaria, but other drugs may follow depending on the outcome of the surveys.

In all of this work, the partnership with WHO plays an important role in ensuring that the interventions follow international standards and recommendations and are evidence based. Germany, therefore, is also supporting Special Programme for Research and Training in Tropical Diseases in its work to strengthen research capacity in partner countries as one contribution to improving the knowledge base on neglected tropical diseases. A number of research institutions and universities from Germany and their network, the Society for Tropical Medicine, are cooperating closely with WHO programmes through secondments and sharing of expertise and research. The contributions to the onchocerciasis and schistosomiasis control programmes are examples of previous commitments.

Italy, Ms Lucia Fiori, Minister Counsellor, Permanent Mission of Italy to the United Nations in Geneva and other International Organizations in Switzerland

Italy has been historically involved in the fight to eliminate the tropical diseases that affect the poorest populations of the world. Our engagement in the control and elimination of schistosomiasis, intestinal helminthiasis, onchocerciasis and trachoma has been maintained throughout the years within endemic countries.

I would like to take the opportunity of this fantastic partnership meeting to express our heartfelt congratulations to WHO and, in particular, to Dr Chan for having taken the initiative to renew the global fight against neglected tropical diseases; and for having adopted, especially, an innovative approach to synergize vector control programmes with the aim of developing or reinforcing primary health-care systems.

I am here to express my country’s intention to continue to support, not only technically but also financially, all this action in favour of the poorest of the poor to promote health as a
fundamental human right and a key step towards socioeconomic development and peace. From this point of view, my country is also committed, especially with our European Union partners, to keep anti-disease among the top issues on the international health agenda. We really want to reach the goal of complete eradication of these diseases because for us it is extremely important.

USA, Dr Mark L. Eberhard, Director of Division of Parasitic Diseases, Centers for Disease Control and Prevention

On behalf of the United States Public Health Service and the United States Centers for Disease Control and Prevention, it is indeed a pleasure for me to have an opportunity to make these brief comments about the commitment of the Division of Parasitic Diseases to the control of neglected tropical diseases. The Division of Parasitic Diseases, through its field stations in Central America, first in El Salvador and now in Guatemala, has had an active programme in onchocerciasis control for over two decades. The United States Centers for Disease Control, along with other founding partners of the Pan American Health Organization, The Carter Center and the ministries of health of the six endemic countries, form the Onchocerciasis Elimination Program of the Americas. This program is now substantially funded by the Bill & Melinda Gates Foundation, the Lions Club and Merck & Co., Inc.

World Organization for Animal Health (OIE), Dr Tomoko Ishibashi, France

On behalf of the Director General of the Office International des Epizooties (OIE), I would like to thank WHO and Dr Margaret Chan for inviting us to this important meeting and to express our support for WHO’s objectives in control of neglected tropical diseases.

Let me focus here on zoonoses, as that is our mandate. The OIE animal disease notification system is a starting point. As is often said, hiding cases of infection in animals is an important warning sign for the human population. The OIE early warning system generates needed information on certain zoonoses. Zoonotic potential is one major criterion for inclusion in the list of notifiable diseases. Second, the OIE is recognized by the World Trade Organization as the relevant standard-setting organization for animal health and zoonoses. The OIE code defines standards for the avoidance of importation of pathogens and for surveillance of animal diseases. For important zoonotic diseases such as anthrax, bovine tuberculosis, brucellosis and avian influenza, the OIE code stipulates recommendations for international trade to prevent the spread of pathogens. We believe these activities surely contribute to controlling zoonoses, although not targeting them directly. However, OIE’s most important contribution is, perhaps, our initiative to strengthen the veterinary services of our Member countries. The OIE views many capabilities as critical to control zoonoses, such as improving public awareness, surveillance, rapid containment response, reporting, cooperation with the public health sectors and field and laboratory diagnosis.

[…] We believe that the strengthening of veterinary services is one of the most fundamental ways to address the problems of prevention and control of neglected tropical diseases by implementing policies to reduce pathogens at their animal source.
Turning targets into treatments

“Industry is present. Your donations of drugs and other support opened an opportunity which public health has seized. Your engagement has given us the tools to take action on an unprecedented scale. We have set ambitious goals and supported these with technical strategies for implementation.”

Dr Margaret Chan
Director-General, World Health Organization

My colleagues at WHO in Geneva, in the Regions and in our Member States evaluate information about the distribution of neglected tropical diseases and the impact of these diseases on the health of millions of poor people. We consult widely, invite advice from experts, conduct operational research and devise strategies to bring relief from these persistent afflictions. We adopt ambitious targets for control programmes and, through advocacy, we recruit and encourage partners to join the campaign to control neglected tropical diseases. Our targets include extending access to drugs and increasing the numbers of treatments for those at high risk of morbidity.

Much of the effort has been underpinned by the policies and generosity of the pharmaceutical industry. Disease, disablement, disfigurement and social marginalization are being brought under control for millions of poor people thanks to freely donated drugs and drugs made available at very low cost. There exists the perception that pharmaceutical companies are competitive, ruthless business machines committed to generating wealth for shareholders. If the pharmaceutical industry failed in its quest for profit, however, there would be no safe and effective drugs, there would be no donations – in short, we would be making little progress in our effort to control many of the neglected tropical diseases. The dedication and support of the pharmaceutical industry is crucial for the control of neglected tropical diseases, and we gratefully acknowledge their many contributions.

Dr Lorenzo Savioli, Director, Control of Neglected Tropical Diseases, WHO, Geneva, Switzerland
In the 21st century, in the less developed countries of the world, every day over a billion people suffer, needlessly, the terrible consequences of the neglected tropical diseases that have affected them for generations.

These populations are neglected in the sense of limited access to basic health services, basic information on how to seek care and awareness of the simple ways to prevent and treat early on what will later make their lives an ongoing sufferance.

Health-care systems in these countries cannot deliver the essential services to their needy populations because of the shortage of human and technical resources as well as limited finances.

These poorest among the poor spend their lives deprived of opportunities to develop and profit from all that the 21st century has to offer, as these diseases leave them blind, disfigured, disabled and, eventually, possibly dead.

These conditions have a long-lasting impact on children, depriving them of their childhood and limiting their access to education. Social deprivation and deteriorating health services have resulted in the spread of many infectious diseases such as trachoma, which might eventually lead to incurable blindness if not treated in its early stages.

Trachoma affects the poorest and most remote rural areas of 56 countries in Africa, Asia, Central and South America, Australia and the Middle East. It is considered as one of the major causes of preventable blindness globally. An estimated 80 million individuals are affected by trachoma, the majority of whom are children; around 10 million people are at immediate risk of losing their sight as a result of complications, the majority of whom are women living in Africa.

Since its launch in 1997, the WHO Alliance for the Global Elimination of Blinding Trachoma, combined with socioeconomic development in endemic countries, won a major victory in fighting trachoma. The estimated number of people affected by trachoma has fallen from 360 million people in 1985 to approximately 80 million people in 2007.

Control of trachoma is achievable through combined efforts at national and global levels along with the implementation of the WHO SAFE strategy. Trachoma is one of the few diseases that can be successfully eradicated. Several countries including the Islamic Republic of Iran, Mexico, Morocco and Oman have recently been declared free of active transmission, thanks to continuous improvements in environmental and social conditions as well as health services in accordance with the SAFE strategy. Not forgetting the partnership with the corporate sector as evidenced by Pfizer, which generously donates the drug needed to treat trachoma.

In this regard, I am pleased to refer to resolution WHA 59.25 concerning prevention of avoidable blindness and visual impairment, which requests the WHO Director-General to give priority to prevention of avoidable blindness and visual impairment. It also requests the Director-General to add prevention of blindness and visual impairment to WHO’s medium-term strategic plan 2008–2013 and proposed programme budget 2008–2009.

I therefore urge you all to support the inclusion of prevention of avoidable blindness and visual impairment in the strategic plan, which will be discussed at the 60th World Health Assembly in May. The result is not only freedom from diseases but progress of communities and individuals through the availability and the proper delivery of health services, resulting in prosperity and peace.

In these times where we see so much disparity among human beings, the implementation of proven, effective strategies for disease control, delivery of drugs generously donated by the industry to those who need them and making surgical care available to the needy are fundamental contributions to the Millennium Development Goals.

We shall all engage for the benefit of the forgotten and the neglected among us who need our help and resources, to move from the oblivion to a way of living that spells dignity and empowerment.

We shall all unite and cooperate with governments, intergovernmental organizations, civil society and the corporate sector, which believe in their social responsibility in order to maintain momentum and achieve our goals.

We shall work vigorously to engage new partners and new stakeholders to work with us until the last community is freed from this needless sufferance.

Countries are affected as well, as all these masses of impoverished people propagate the vicious circle of poverty, hampering attempts and efforts to provide better living conditions through generalized development.

We have solutions for these diseases. There are countries that have recently eliminated some of them through sustained political will, coordinated international partnerships and implementation of proven, effective strategies.
Bayer HealthCare AG, Dr Kemal Malik, Head of Global Development and Compliance, Germany

[...] “Science for a better life” is the slogan of our Bayer Group. [...] Our commitment underscores our willingness as an inventor company to help shape the future and our determination to come up with innovations that improve health care and benefit humankind. [...] Patients with neglected tropical diseases should be supplied with suitable medicines for medical, ethical and political reasons.

[...] As an example, we do have established successful collaborations with WHO in the fight against African sleeping sickness and Chagas disease.

In November 2002, an agreement between Bayer HealthCare and WHO was signed to provide the product Germanin® (active ingredient suramin) free of charge for an initial five-year period in the amounts forecast by WHO.

Only two weeks ago, Bayer HealthCare AG signed a new agreement to support WHO in its fight against Chagas disease by providing 2.5 million tablets of Lampit® and additional financial funding.

The latest agreement assures the supply of Lampit® for the next five years. This is a further step to address areas of unmet medical need and neglected diseases.

WHO is an excellent partner for such activities, and we would like to thank the present representatives for their dedication and commitment.

Global Alliance to Eliminate Lymphatic Filariasis, Professor David Molyneux, Executive Secretary, UK

Lymphatic filariasis is one of the most disabling diseases. It is endemic in some 80 countries with 40 million people grossly disabled or deformed by the lesions that stigmatize communities, individuals and families. Some 120 million individuals are estimated to be affected, with 1.3 billion people at risk. Such a situation, however, should no longer exist given the availability of simple and cost-effective public health interventions. Several countries, including China, have arrested progression of this disease and its transmission in China in a population of 350 million.

The lymphatic filariasis programme has scaled up rapidly from its inception in 2000, when 12 million people were treated, to 2005 when globally 381 million people were treated with antifilarial drugs to reduce the risk of transmission, that is 381 million people. That is probably the most rapid scaling up of a public health programme currently in the world; 42, or roughly half the number of endemic countries, now have active programmes and are committed to the elimination of the disease.

Egypt, following the strategy recommended by WHO, has demonstrated that the parameters of success, as defined by the absence of transmission, have been fulfilled in a population of 2.5 million people in the Nile Delta since 2005 and since the programme started through six rounds of mass drug distribution. In sub-Saharan Africa, where significant progress has been made using the Mectizan®/albendazole combination, control and elimination provides an umbrella for assisting not only the cessation of transmission of filariasis but also control of onchocerciasis and intestinal worms.

In Burkina Faso, 10.4 million people have benefited from Mectizan®/albendazole over the past two years. The cost of this intervention was calculated to be US$ 0.6, or six cents per person per year treated, with funds provided very largely by the government itself.
Geneva Global Inc., Mr Mark Forshaw, Health Sector Manager, USA

I have been very encouraged by the profiling of the issue of partnership; and there are two key elements of partnerships that I want to mention because I think they have been mentioned only briefly but they are fundamental to the company I work for, Geneva Global, namely individual philanthropists and, at the other end, community-based organizations.

My first thank you is for having invited Mrs Hashimoto to speak to the meeting at such a high profile. Individual philanthropists will be inspired by her contribution.

My second thank you is to the delegates who profile the work of community-based organizations. If you want to ensure coverage, impact and sustainability in communities, we have to work with community-based organizations that are truly community based, local nongovernmental organizations and faith-based organizations, which themselves have a very positive attitude of partnership with their national governments. So, thank you for that profiling by other delegates.

My third thank you is for the opportunity to state that it has been a privilege to be here as a former community health worker in Africa and former WHO staff member. Now I am someone who is better equipped by our partnership with the Schistosomiasis Control Initiative in Burundi and Rwanda, where we have recently facilitated, on behalf of an individual philanthropist, US$ 8.9 million to reach 7 million people, addressing five neglected tropical diseases and also working with the network for neglected tropical diseases. That has been a partnership from which we are greatly benefiting. I also take away from this meeting a challenge and a hopeful message to those with the ability to fund change in millions of lives.

GlaxoSmithKline, Dr David Stout, President, Pharmaceuticals Operations, USA

[…] As an example of what partnerships can do, you need only look at Lapdap™, the antimalarial that we developed in partnership with the Liverpool and London Schools of Tropical Medicine, the Special Programme for Research and Training in Tropical Diseases and the UK Department for International Development. Lapdap™ was approved in 2003. That partnership has now been extended to the development of Dacart™, an artemisinin-based combination therapy currently in Phase III development.

 […] We believe in making our medicines available to people who cannot afford them. In 1998, GlaxoSmithKline made a commitment to WHO to work through them and an alliance of global partners to eliminate lymphatic filariasis. This neglected tropical disease, which is spread by mosquitoes, afflicts over 120 million people. A further one billion people are at risk of the disease, which is often referred to by its clinical manifestations — elephantiasis. GlaxoSmithKline has committed to donate its anti-parasitic drug, albendazole, to WHO for every country that needs it until lymphatic filariasis is eliminated. The commitment will entail billions of albendazole tablets over at least 20 years. To date, we have donated over 600 million albendazole treatments to more than 40 countries that have commenced elimination programmes. While a good start, much more needs to be done to reach all 80 endemic countries.

 […] Why do we do it? […] we do it because we can.
Sabin Vaccine Institute, Professor Peter Hotez, President, USA

Possibly never before have leaders from so many different disciplines come together to help the world’s poorest people in such a visceral and tangible way. Imagine, representatives of the largest multinational pharmaceutical companies working side by side with academics and scientists together with the Bill & Melinda Gates Foundation and other private philanthropies together with their grantees, the partnerships of the global network such as the Schistosomiasis Control Initiative, the International Trachoma Initiative, GAELF, APOC, Sabin Institute, The Task Force, Helen Keller, The Earth Institute, as well as the Carter Center, together with the World Bank, national ministries and perhaps, most importantly, together with the district health managers and community distributors, all working together to deliver packages of drugs that will, one day, lift the world’s poorest people out of poverty.

Today, I am happy to announce that Geneva Global has just donated, on behalf of an individual philanthropist, US$ 8.9 million to the Global Network and its partners, the Schistosomiasis Control Initiative and the Earth Institute, to deliver drug packages to national control programmes in Burundi and Rwanda. I also want to announce the appointment of TV and film star Miss Melissa Milano as Honorary Ambassador for the Global Network, along with a personal financial commitment to the Global Network that will be given to WHO for the purchase of 10 million doses of diethylcarbamazine. These activities will be highlighted at the mid-year meeting of the Clinton Global Initiative in New York, USA.

Johnson & Johnson, Dr Sharon D’Agostino, Vice-President, Worldwide Corporate Contributions and Community Relations, USA

We applaud WHO for its leadership in the effort to eliminate neglected tropical diseases as public health problems.

One disease of particular concern and interest to Johnson & Johnson is soil-transmitted intestinal worm infections, widely found in tropical and subtropical areas with limited access to clean water and sanitation. Symptoms include diarrhoea, tiredness, abdominal swelling and pain. Intestinal worms are especially dire for children because they cause malnutrition, increase susceptibility to other serious infections and stunt growth during a critical period of development. And if children are not treated, the disease may lead to impaired cognitive development, reduced school attendance and performance and, ultimately, decreased productivity as adults. In severe cases, these infections can lead to death.

Intestinal worm infections represent a major public health burden. Globally, 400 million children are estimated to be at risk, with the highest rates of infection in children aged between 5 and 15 years. We know that even in the highest-risk, highest-transmission areas, regular treatment will stop the infection from developing into serious disease. This is why Johnson & Johnson – which has a heritage of caring for babies and children – has committed to donate 50 million doses of mebendazole in 2007 for mass treatment of children most at risk of this infection in countries with limited access to safe and effective treatment.

This donation reflects Our Credo responsibility to the communities in which we live and work, and reflects our philanthropic mission to make life-changing, long-term differences in human health by targeting the world’s major health issues.

Together with governments and communities, we can all help to contribute to a healthy future for children, filled with promise and potential.
MedPharm, Mr Andrew Koval, President and Chief Executive Officer, USA

I also want to acknowledge the tremendous contributions made by the private sector pharmaceutical companies beginning with Merck & Co., Inc’s donation commitment since 1986 and continuing with today’s announcement by Merck KGaA of Germany of their donation. MedPharm is pleased to have been an early pioneer and to have expanded our commitments, contributions and donations in each of the past 12 years.

Twelve years ago, working with WHO, the Pan American Health Organization and various nongovernmental organizations, MedPharm developed its special formula of single-dose, chewable and peppermint flavoured mebendazole tablets (500 mg). Independent studies conducted among 100 000 school-aged children under United Nations supervision confirmed the high acceptance, and we then applied this formulation to MedPharm’s single-dose, chewable and peppermint flavoured albendazole tablets (400 mg).

During the past 12 months, MedPharm has provided to nongovernmental organizations, WHO and other United Nations organizations, as well as ministries of health worldwide, more than 60 million tablets of mebendazole and albendazole; 60% or 36 million tablets were donated. These donations are facilitated by private sector donors including the World Health Initiatives, Canadian and American charities and foundations, as well as private companies and individuals.

In another example, MedPharm has for the past four years steadily increased its donations of praziquantel to African programmes of the Schistosomiasis Control Initiative […] Over the past 12 months, MedPharm has provided more than 22 million tabs of praziquantel (600 mg), of which 16 million tabs were donated. This enabled the Schistosomiasis Control Initiative to substantially leverage the impact and outreach of their US$ 40 million Bill & Melinda Gates Foundation grant. With our private partners, we will expand the level and the outreach of these donations of mebendazole, albendazole and praziquantel in the coming years.

I am pleased to announce that in response to a request from Dr Savioli, MedPharm will donate 1 150 000 tabs of mebendazole to launch a deworming programme in Benin. Following Dr Savioli’s request last year, we arranged a donation of mebendazole to cover WHO’s commitment in a joint United Nations-sponsored deworming programme in Afghanistan that treats annually over 5 million schoolchildren. We continue this commitment in 2007.

Merck KGaA, Mr Elmar Schnee, Member of the Executive Board and Head of the Merck Serono Division, Germany

Remembering that we have a responsibility to the community is part of our corporate culture. Volunteering to provide for a better future at all our sites around the world is thus one of Merck’s guiding principles. With our social and cultural commitment, we are also working towards the implementation of the United Nations Millennium Development Goals and the principles defined by the United Nations Global Compact.

It therefore gives me great pleasure to announce that Merck KGaA has entered into a 10-year partnership with WHO to combat schistosomiasis in African schoolchildren. For this purpose, Merck will provide free of charge 200 million tablets of Cesol® 600 (active ingredient praziquantel) with a value of approximately US$ 80 million. In this way, Merck will ensure the treatment of around 80 million cases in the next 10 years so that children in countries affected by diseases of poverty have a chance for a healthy life. With more than 200 million infected, schistosomiasis is the second most common tropical disease in Africa after malaria. In children, schistosomiasis leads to anaemia, stunted growth and learning difficulties.

The Merck-WHO partnership to fight schistosomiasis is further evidence of the major efforts being undertaken by research-based pharmaceutical companies to combat neglected tropical diseases. Health is not everything, but everything is nothing without health. That is why we perform research.
While research and development are fundamental to our business success, we know it is also critically important to help make our medicines and vaccines available to those who need them. This is particularly true in the developing world, where access to medicines is often limited by inadequate health-care infrastructure, lack of expertise and insufficient political will.

The best example of Merck’s commitment to developing world health in the area of neglected tropical diseases is the Merck Mectizan® Donation Program.

The development by Merck scientists of Mectizan® in the 1980s, and the clinical studies conducted with WHO’s Filariasis Unit and TDR programme that resulted in Mectizan’s regulatory approval, represented a great step forward in the fight against onchocerciasis – one of the world’s most debilitating tropical diseases.

Since Merck initiated the donation of Mectizan® in 1987, more than 530 million treatments have been donated at an estimated value of US$ 2.7 billion dollars.

The programme currently reaches more than 60 million people in 34 countries in Africa, Latin America and the Middle East (Yemen) each year for the treatment of river blindness.

The broad partnership developed through the Mectizan® Donation Program also includes a group of dedicated nongovernmental development organizations and all the endemic countries and communities. Working together, this coalition has made a substantial impact in the fight against river blindness.

The programme prevents an estimated 40,000 cases of blindness annually in endemic countries, and has contributed to the recovery of more than 60 million acres of previously abandoned arable land in Africa.

A number of countries in Latin America are close to halting the transmission of river blindness. In Latin America, of the 13 original endemic onchocerciasis foci, the Santa Rosa focus in Guatemala will be the first to be able to stop treatment in 2007; 7 additional foci have eliminated new eye disease attributable to onchocerciasis.

In Africa, where transmission of onchocerciasis is more difficult to halt through Mectizan® treatment, twice-yearly treatments are now being used in some areas to attempt to eliminate the disease. A research study is also under way with the Special Programme for Research and Training in Tropical diseases to define the end-point of Mectizan® treatment in Africa.

In economic terms, river blindness programmes using Mectizan® have an economic rate of return of 17% in Africa.

In 1998, Merck expanded its Mectizan® donation to include the elimination of lymphatic filariasis in Africa. An estimated 40 million treatments are approved each year for lymphatic filariasis through Merck’s collaboration with GlaxoSmithKline and the Global Alliance to Eliminate Lymphatic Filariasis. The two diseases are being addressed jointly in an increasing number of African programmes.

Additionally, interventions for trachoma, vitamin A distribution, cataract identification, schistosomiasis control, immunization campaigns, the distribution of insecticide-treated bednets, training programmes for community health workers and census taking – are increasingly being applied through the community-directed treatment model pioneered by the WHO through the Mectizan® Donation Program.

Merck is also a founding member of the Partnership for Disease Control Initiatives – a group of pharmaceutical companies collaborating to share best practices for developing world and neglected tropical disease interventions.

The renewed focus on the global fight against neglected tropical diseases offers great opportunity for the world’s neediest populations. We hope the lessons learnt from 20 years of the Mectizan® Donation Program partnership will inform the process for increased collaboration and coordination to effectively confront the challenge of these diseases.
Novartis Foundation for Sustainable Development,  
Professor Klaus M. Leisinger, President and Chief Executive Officer, Switzerland

I have the pleasure to report a success story. About 14 years ago, on the occasion of the 14th National Leprosy Congress in Orlando, USA, in the summer of 1993, some of us in this room made a silent and not at all mainstream commitment: as leprosy is one of the few diseases that can be eliminated and as we have the means to do so in our hands, let us consign this biblical disease to history.

Six years later in November 1999, the Global Alliance for Leprosy Elimination was set up to ensure that a common strategy based on the experience of past leprosy elimination efforts was adopted. The Alliance brought together all the key players in the fight against leprosy, i.e. the governments of leprosy-endemic countries, WHO, the International Federation of Anti-Leprosy Associations, the Nippon Foundation/Sasakawa Memorial Health Foundation and the pharmaceutical company, Novartis, as well as its Foundation for Sustainable Development. The aim was to detect and cure all remaining leprosy cases, estimated by then to be about 2.5 million.

WHO provided technical and strategic leadership as well as operational guidance. Governments and nongovernmental organizations supported the initiative with their field networks and financial resources. The Nippon Foundation pledged US$ 24 million to help implement the final push, and Novartis pledged to provide multidrug therapy free-of-charge to all patients in addition to the conceptual and technical country-level support, which the Novartis Foundation was providing.

We have not achieved our ambitious target of eliminating leprosy from all countries by the year 2005, but we are nearer to that goal than ever before in human history. The number of known leprosy patients is fewer than 200,000. In January 2008 in Hyderabad, India, we will probably meet for the last time at an International Leprosy Congress.

Let us all be proud of the fact that we have been and continue to be part of the solution of what has not only been an infectious disease problem but a human tragedy for millions of people; and let us get together after January to re-evaluate the situation and come up with an eradication plan. The chance to do this has never been greater. We know what to do and we have the resources to do it consistently. We can write history; we simply have to make it happen.

Pfizer Inc., Mr Robert L. Mallett, Senior Vice-President, President of the Pfizer Foundation, USA

Over a billion people suffer from the diseases we meet to discuss. What stands in our way? I have been in government, where I wrestled with the problems of treating the health problems of poor people. It is very hard to do – I was working in the United States. It is even harder when you are a minister of health from a country with virtually no resources.

Almost half the burden of disease in least-developed countries stems directly from the prevalence of poverty. So change is hard. And yet we must change. How? First, it is clear no one group or company or government can do it alone. I am here because Pfizer wants very much to be part of the solution. But no matter what people think of the private sector, we cannot do everything. The solution must come from partnership: between private, public, and organizations like WHO. That means putting aside the philosophical differences we have and finding common ground. That is why we should applaud the plan put together by the partners.
What we have done with WHO is foster an excellent, extraordinary partnership. Extraordinary because it has been successful. We worked together in the beginning for five years on sleeping sickness. We supply the drugs, but that would not have been enough if, at the same time, a great deal of training work had not been done in order to be able to diagnose the disease and to screen for the disease in the field.

Our friends from Médecins sans Frontières helped us distribute the drugs, and that was an essential contribution. Some 14 million treatments were carried out in that area, and everybody agrees that about 110 000 people were saved thanks to this campaign, thanks to these measures. The number of new cases of sleeping sickness at the end of 2005 was under 17 000, which is a very important result. We will continue, of course, dealing with sleeping sickness, but we decided, with WHO, to fight four other important diseases. We decided to fight together against leishmaniasis. I mentioned drugs against malaria, which will be produced by our Moroccan friends where we are working here with IDM and DNDi. Brazil is going to supply drugs for leishmaniasis at a non-profit price: no profit, no loss, if we can put it that way. We will try not to lose money, but we are sure we will not gain any money. In doing this we will bring down the cost of the treatment, Glucantime (meglumine antimonite). We have also decided, with WHO, to work on Buruli ulcer and Chagas disease, and we will also be giving money.

We have mentioned a number of neglected diseases here. Unfortunately, throughout the world, there are many neglected diseases even if they are not called neglected diseases. In conclusion, I would like to express yet again my thanks to WHO and its staff. Thanks to them we have obtained the results I have just mentioned in struggling against sleeping sickness. Altogether, we have grown, altogether we now have the impression that we are doing our job as men and women.

Shin Poong Pharm. Co., Ltd.,
Mr Won-June Chang, Managing Director, Republic of Korea

[...] Shin Poong is one of the leading pharmaceutical companies in the Republic of Korea, with three manufacturing facilities in China, Sudan and Viet Nam.

In many endemic countries, nongovernmental organizations and industries are working closely together to fight against these neglected diseases under the leadership of WHO, and Shin Poong gives unstinting praise to these organizations.

Starting with mebendazole, a broad-spectrum anthelmintic, Shin Poong is closely collaborating with WHO to supply and distribute affordable generic anthelmintics to endemic countries. For the past decades, Shin Poong has supplied 16 million tablets of praziquantel and 260 million tablets of mebendazole and albendazole to these countries. Shin Poong also supplied over 100 million tablets of praziquantel to endemic countries to support the eradication campaign.

It is our responsibility to spread the benefits of modern technology to those who are in need. Initiatives started at this meeting could be the turning point, where the word “neglected” no longer applies for tropical diseases.
I should like to report on the successful private-public partnership that led to the approval of a new, innovative, therapeutic modality against visceral leishmaniasis. This disease is expected to have 500,000 new infections annually, predominantly in Bangladesh, India and Nepal, with 60,000 deaths.

In collaboration with our company Æterna Zentaris, the Special Programme for Research and Training in Tropical Diseases and the Indian Government, we were successful in developing miltefosine as the first oral treatment in this indication. The studies were done predominantly in Bihar. We were treating about 800 patients, one third of them children. A high proportion of those with this disease are children. This led to the approval of a 28-day therapeutic regimen with only one or two capsules daily. The regimen cures patients in more than 95% of cases, including also those who were primarily resistant against the standard therapy. The conditions and field use were also demonstrated to have safe and efficacious records in the same study with 1300 patients. This study was done in collaboration with the Indian Government and then the Nepal Government.

A big Phase IV study is running at present in Bangladesh. In summary, we have been successful in developing the first oral treatment against visceral leishmaniasis, and we have established clinical centres and a clinical infrastructure in Bihar that are very important for the development of new drugs in this and other areas. As proof of the quality of the data, all our publications were accepted by the most prestigious medical journals including the Lancet and the New England Journal of Medicine.

I would like to take the opportunity to thank everybody who participated in this programme.
“This geographical overlap means that people are often affected by more than one disease. It also means that strategies developed to deliver interventions for one disease can rationally be used to deliver interventions for others. This opens opportunities for integrated approaches, for simplification, cost-effectiveness and streamlined efficiency. […]

Let me repeat: our mandate must come from ministries of health. It is good to have so many health ministers present in this room and to know that these diseases are receiving priority.”

Dr Margaret Chan
Director-General, World Health Organization

Sudan, His Excellency Abdulmagid Elmajed Mohamed Nour, Minister of Health, Federal Ministry of Health

It gives me great honour as the Minister of Health of Sudan to thank WHO for organizing this meeting and to join with the global partners at the meeting. In Sudan, a lot of effort has been made with the help and assistance of international nongovernmental organizations and international agencies concerning many diseases.

Now we have schistosomiasis as one of the major diseases, with 2.2 million fedans in the Gazira Scheme. Another six sugar factories employ around 24 million people at risk for schistosomiasis, with 5 million people infected and a prevalence of 20.8% of the total community infected by schistosomiasis. Good assistance and efforts and help from WHO reduced the prevalence in Gazira State from 56% to 1% during the period of 2005–006 using mass chemotherapy.

Around 9000 cases of leishmaniasis have been reported in eastern Sudan, in the centre of Sinnar Bruni and also in Upper Nile. Efforts with Médecins Sans Frontières in Holland and France have played a major role in reducing the morbidity and mortality of leishmaniasis, especially its visceral, cutaneous and mucocutaneous forms.

A determined effort has been made against lymphatic filariasis using mass drug treatments with albendazole and ivermectin. The effort against onchocerciasis continues, and guinea-worm disease has been eradicated from around
10 out of 17 states through The Carter Center. In collaboration and coordination with the German Leprosy Relief Association, a noble job has been done in reducing the prevalence of leprosy to less than 1% in most states, and activities now continue following the signing of the comprehensive peace agreement for southern Sudan.

It gives me great pleasure to record both the strengthening and the capacity building of Sudan’s health system using the Federal and State Health and Local Governance system. With collaboration and consultation of the international agencies and partners, we can sustain these activities and maintain a minimal prevalence of neglected tropical diseases. Again, it gives me pleasure that Sudan is extending its thanks and gratitude to all the nongovernmental organizations and the international community.

United Republic of Tanzania, Honorable Dr Aisha Omari Kigoda, Deputy Minister, Ministry of Health and Social Welfare

My country is endemic for many of the neglected tropical diseases being discussed here. Hence, I strongly believe that I am in the right place at the right time. These diseases are the cause of much suffering and disability, and they also perpetuate a cycle of poverty and adversely affect people’s productivity. My country has been at the forefront of tackling diseases such as schistosomiasis, lymphatic filariasis, onchocerciasis, intestinal helminthiasis and trachoma. We do acknowledge, however, that a concerted effort to address these diseases in a more integrated fashion will be more cost-effective and allow better use of the meagre resources that we have.

Uganda, Honorable Dr Stephen Mallinga, Minister of Health, Ministry of Health

Uganda, as one of the sub-Saharan African countries, is burdened by neglected tropical diseases. In its position in the continent, it has more than its share of these diseases, which include lymphatic filariasis, onchocerciasis, schistosomiasis of both types (intestinal and urinary), human African trypanosomiasis of both forms (gambiense and rhodesiense) and trachoma. In addition, visceral leishmaniasis and Buruli ulcer are present in a number of foci in the country. Guinea-worm disease has now been virtually eradicated in Uganda, thanks to The Carter Center. Leprosy has been significantly reduced, thanks to Novartis and the German Government.

Populations at risk range from 2 million people for onchocerciasis to 22 million for intestinal helminthiasis. The number of people infected with more than one disease, so-called multiple disease infection, is very high in our country. The neglected tropical diseases impose massive economic and morbidity plus disability burdens on the country, which is troubling with the many development demands. In addition, these diseases are viewed as a major human rights issue because of the close linkage with poverty, discrimination, stigma and the right to health.

The linkage with the right to health and human rights is very much recognized in Uganda. In March 2005, the Government of Uganda invited the United Nations Specialist Rapporteur, Professor Han Paul, to visit Uganda with a view to examining the issues of human rights and health, particularly as related to neglected tropical diseases. The mission was a success, and several recommendations were made to the Government of Uganda. The Rapporteur returned to Uganda in February this year as a follow-up visit. Many of the recommendations made in 2005 have been implemented and some are in the process of being implemented. The recommendations included access to health information and education, community participation, human resources and health professionals tackling stigmatization and discrimination, an integrated health system response, local priorities, health research and development, monitoring, and accountability and role of donors, partners and the international community in the control of neglected tropical diseases.

I am indeed glad and privileged to participate in this important global partners’ meeting. Neglected tropical diseases are an impediment to the attainment of the Abuja Targets set by the African Union and the Millennium Development Goals. In Uganda, after 2002, there were several vertical programmes addressing the different neglected tropical diseases. In 2002, the Minister of Health adopted a policy of
integrated service delivery and this is very well spelled out in the Health Sector Structure Plan Two. This form of integration uses Child Health Days as a platform. These days were originally meant to be periods of accelerated child health interventions against childhood and maternal illnesses. Held twice a year, that is in the months of May and November, since 2005 additional interventions have been added and are now referred to as Child Health Days Plus. The additional interventions include de-worming of children aged below 14 years, vitamin A supplementation to children aged below 5 years and mothers who have recently delivered; as well as distribution and treatment of insecticide-treated bednets, mass drug distribution in the districts affected by schistosomiasis, lymphatic filariasis, onchocerciasis and trachoma, and provision of Health Education and Health Promotion packages.

I am glad to report that Child Health Days Plus have been able to bring together major departments and programmes in the Ministry to work together, including other sectors such as the Ministry of Education and Sports, and Gender and Social Development, partners, United Nations agencies, university and other training institutions, and nongovernmental organizations working in the health sector. They are all well coordinated in the planning and implementation of the programme of Child Health Days Plus. This arrangement has proven beneficial to all programmes and has had a massive synergistic effect. The operational costs have been substantially reduced as we have gone along. Health service delivery has been decentralized at the district level down to the communities where the trained village health communities and teams are charged with the responsibility of identifying community health needs. Community health workers and community drug distributors fully participate in Child Health Days Plus. We owe the success of Child Health Days Plus to this group of people.

We lack adequate financial resources, just like any other country, to carry out key activities such as advocacy, training and social mobilization. Supervision, monitoring and evaluation remain inadequate. We still have a few partners with funds that are tied to specific programmes with special demands. Multiple endemicity in some areas causes a big challenge. However, we feel that, as a country, we have embarked on a worthwhile challenge. It is our hope that we shall achieve our goal in eliminating and eradicating most of the neglected tropical diseases.

Lastly, I wish to pay tribute to all our partners who have supported us throughout this period. We thank WHO for technical guidance and providing a secretariat for the coordination of the partnership in the country; the Danish bilharziasis laboratories for training, capacity building and control of parasitological diseases; The Carter Center for support to onchocerciasis and guinea-worm disease control programmes; the Schistosomiasis Control Initiative for the schistosome and soil-transmitted helminth control activities; and all the drug companies that have organized the distribution of drugs – to mention but a few, GlaxoSmithKline, Merck & Co., Inc., Johnson & Johnson, Pfizer and GlaxoSmithKline.

Myanmar, Dr Kyaw Nyunt Sein, Deputy Director General (Disease Control), Department of Health, Ministry of Health

The neglected tropical diseases are all important priorities. However, it was difficult to focus appropriately and respond systematically and adequately in the past. This led to discrimination and discrepancies, leading to disability, deformity, blinding, stigmatization and death. Millions and millions of people had needlessly suffered in terms of socioeconomic deprivation and poverty, generation by generation. These diseases became the proxy indicator for poverty. Why do we neglect them? We used to say that higher priority was given to other diseases threatening international health security. For me the answer is not complicated.

Some 30 years ago, before the emerging of diseases like HIV/AIDS, severe acute respiratory syndrome and avian influenza, the Declaration of Alma-Ata mentioned the need to combat locally endemic diseases as one of the elements of primary health care in developing countries, which is where the neglected tropical diseases prevail. We failed to grab such opportunities fully. Nowadays, we have cost-effective strategies and could demonstrate successes in the control, elimination and eradication of some public health diseases. We have a strong partnership to fight against these diseases.

Our responsibilities as today’s generation is to promote the success of control of the neglected tropical diseases nationally as well as globally and to expand the success for other such diseases as well. In Myanmar, we have made strong efforts; we have conquered some
tropical diseases that are globally targeted for elimination and eradication. We eradicated polio and eliminated leprosy in the year 2003 with the strong commitment and leadership of our government and the participation of entire communities and partner agencies, both national and international, in all aspects. We achieved our objectives in the most cost-effective ways.

At present, we are sustaining the achievements and reducing the burdens of these diseases on the one hand; at the same time, we are achieving the elimination of some other diseases such as neonatal tetanus, measles, trachoma and lymphatic filariasis and with limited resources. Although we have the policy and plan to combat locally-endemic diseases, there are some tropical diseases we are not neglecting. The response is limited because of the scarce resources and insufficient tools to control soil-transmitted helminthiasis, rabies and cholera. Although we want to cure and contain these diseases, prioritization is unavoidable. Some other tropical diseases, such as Japanese encephalitis and food-borne trematodiasis remain neglected because of lack of tools and lack of valid data and information.

Assessment of the burden of disease and surveillance are urgently needed. Today we can set objectives to prevent, control and even eliminate and eradicate some selected neglected tropical diseases.

Thanks to the WHO initiative and leadership in providing a good platform to combat neglected tropical diseases, we shall make progress. There are many other important diseases that do not get enough focus, for example, zoonotic diseases and other noncommunicable diseases such as anaemia.

Our government has increased investment in the health sector for the development of our country in terms of improving health facilities and the health infrastructure, increasing and improving the capacity of human resources for health and strengthening the health system, which are good and essential cornerstones for laying down the health-care delivery services. One of our objectives is to attain the highest level of health for all our citizens. We have no doubt that the neglected tropical diseases are strongly linked with poverty, and the conquest of these diseases would contribute to the attainment of the Millennium Development Goals. But here I should like to share my concept: why do we need to combat neglected tropical diseases? The answer is very simple: because of the ethics of our health professionals and also equity for sufferers of any diseases. Poverty alleviation, reducing the burden of HIV/AIDS, TB and malaria, achieving the Millennium Development Goals are all human benefits. However, we have to collaborate with other stakeholders by using the right to health, disability-adjusted life-years and health economics as advocacy tools.

We strongly believe that, along with the coordination and harmonization of international assistance and concerted efforts of many countries, we will conquer these diseases within the set time frame. Among many innovations for control, an intersectoral and interprogrammatic medical approach that focuses on populations and integrated interventions rather than disease-specific approaches is the big breakthrough of the current service delivery system. If we can demonstrate this approach successfully, the service delivery system could be changed. The available resources could be used more effectively and efficiently.

Here is where I would like to express my sincere thanks to international agencies, foundations and, pharmaceutical companies for your kind assistance, through which we can make great progress. In conclusion, by making strategic investments to combat the neglected tropical diseases, quality of life will be improved, poverty will be alleviated and, finally, we can have a safer future.

India is committed to all the directions that are being taken globally to control the neglected tropical diseases. They are a big problem in India and are one of the group of diseases that take away a lot of human working days from this country. I welcome all the partners who are gathered here for this important meeting.

The neglected tropical diseases that prevail in India are leprosy, filariasis, glaucoma and soil-transmitted helminthiasis. I would like to include cholera also. India started its leprosy elimination programme in 1993 with a target of achieving less than one case per 10,000 by 2005; this goal was achieved in 2005 thanks to the very sound partnership through WHO for community assistance for these diseases. The target is now to reduce the prevalence rate in the seven remaining states – prevalence currently ranges between 1% and 2%, to below 1%. We are plan to forge a strong partnership with INP ORILP hospitals so that we can bring about changes in
the deformities of those patients who have been declared cured of leprosy.

Lymphatic filariasis is the second disease that is quite prevalent in the country. It affects some 200 districts, and its elimination is targeted for 2015. Initially, we had a policy of mass drug administration with DEC only. With this policy, we were able to cover about 70% of the population up to 2006. This still left 30% of the population remaining and, in a country like India, this is a very huge population. We also changed our drug policy from DEC to DEC plus albendazole in 2005, and we hope to ensure that both these drugs are used in the next round (due in November 2007). This requires positive support from our partners so that the supply of albendazole is provided at the appropriate time. We have already put up the requirement to WHO for about 500 million doses for the next round.

Cholera is a problem that affects 5 of India’s 36 states, with an at-risk population of 129 million. We have taken up the task of eliminating cholera in India by 2010 using new initiatives such as the rapid diagnostic kit.

The health sector in India is currently in a transitional mode. From an investment of 0.9% to the health budget we have gradually increased to 1.3% of GDP, and we plan to make it approximately 2% in the coming one or two plans. This is necessary if we are to fight, in a sustainable manner, the disease burden caused not only by neglected tropical diseases but also other diseases that are common in the country. India is merging all its vertical national programmes, the programme for the vector-borne diseases and leprosy, into one solid national food and health mission programme.

This programme requires a lot of activity to be strengthened at the district level, because the total hub of activity will become a district matter and, with 623 districts in the country, the demand for the number of professionals required, particularly health workers, and management and finance personnel, has grown tremendously. They will also be required for meeting our target for neglected tropical diseases, and they are definitely required to forge a better partnership in this sector. We know full well that the partnership is absolutely essential if we want to take care of health and nutrition in a big country like India. We are all open to partnership in all the sectors that are a matter of concern for us as well as for the providers, but the partnership should look after the interests of both the groups. It is not only the drug sector where we have to have partnership. We will have to have partnerships in other sectors also where we require capacity building. These developments can only be possible if there is the global winner, there is a global direction and there is a global commitment. With this type of initiative taken by WHO, I am sure that we will be able to fulfill our dreams and wipe out all those diseases.

United Republic of Tanzania, Honorable Sultan Mohamed Mugheiry, Minister of Health & Social Welfare, Zanzibar

I would like to join others in extending our sincere gratitude to the organizers of this meeting, which provides an opportunity to discuss good practice and to forge the way forward in tackling the neglected tropical diseases. The topic is so dear to us in the least-developed countries, and we therefore welcome the outcomes of this important meeting.

The Government of Zanzibar has established an integrated disease control programme under my guardianship that aims to mitigate the negative impact of neglected diseases. We are deploying our available resources, but we appeal to our traditional donors and other interested stakeholders to extend their technical and financial support in these endeavours.

The communicable tropical diseases prevailing in Zanzibar include malaria, schistosomiasis, soil-transmitted helminthiasis, human lymphatic filariasis and leprosy. So many interventions have been launched, and several control programmes have been put in place. Consequently, we have already seen positive results. For instance, good results have been recorded in the fight against schistosomiasis as well as soil-transmitted helminthiasis by reducing their significant prevalence.

In 2003, the Minister of Health and Social Welfare of Zanzibar signed an agreement with the Schistosomiasis Control Initiative with the objective of controlling schistosomiasis and soil-transmitted helminthiasis among the local communities of Zanzibar. The four-year agreement (2004-2007) stepped up mass drug administration to the whole eligible community of Pemba Island to contain the high degree of prevalence and widespread distribution of schistosomiasis. The successes are noticeable, and it is with great pleasure that we can share with you such success stories.
Yet challenges abound. For instance, in Zanzibar the management of the lymphatic patient is constrained by financial resources. This forum, therefore, is an appropriate avenue for all of us to renew our commitment in seeking solutions for such situations.

Finally, I would like to thank all partners in general for their support in the fight against malaria to its level of almost total elimination in Zanzibar, and for this we are grateful in particular to the Global Fund and the United States Agency for International Development for the generous contribution without which we could not achieve what we have achieved.

We would like to recognize the generous support from the Bill & Melinda Gates Foundation, Merck & Co., Inc., GlaxoSmithKline, the UK Department for International Development, Global Alliance, GIFE Support Centres and others for their help in fighting lymphatic filariasis. We thank the Schistosomiasis Control Initiative and Health Foundation of British Museum for their support in fighting schistosomiasis and soil-transmitted helminthiasis in Zanzibar. We believe that this integrated partnership could lead to the total elimination of lymphatic filariasis, schistosomiasis, soil-transmitted helminthiasis as well as other neglected diseases in Zanzibar as illustrated in the case of malaria.

Morocco, Dr Noureddine Chaouki, Director, Epidemiology and Disease Control, Ministry of Health

Allow me to congratulate Dr Chan for launching this very great initiative. This memorable day should be celebrated every year as the World Day for the fight against neglected tropical diseases.

In Morocco, we will always be committed alongside WHO in the fight against these diseases. During the past decade, my country has advocated to ensure that these diseases are recognized as top priority. This led to two very important resolutions, one on trachoma (51.11) and one on schistosomiasis (54.19).

In Morocco, we have had no case of malaria registered in our country since 2003, no case of schistosomiasis since 2004 and, currently, we are entering into the consolidating phase for the elimination of blinding trachoma. Since the independence of Morocco, the fight against communicable diseases has always been a priority of the Ministry of Health. Every effort has been made to control diseases, mostly through disease-specific vertical programmes, notably for malaria control since 1965.

In the 1980s, it was decided to integrate disease control into basic health services. In 1982, the schistosomiasis control programme was integrated with the malaria programme and there was a pooling of resources, both financial and human. The trachoma programme was created in 1993 and included all the components of the SAFE strategy.

Our country has achieved very positive results. How did we attain our goals? Mainly through the integration of control processes in the national health system, the political determination and commitment, which is of the most importance, the cross-section collaboration working in the field in close proximity with the communities and also the close involvement of civil society in the context of an approach of sustainable development in the long term. Also, financial and technical support provided by our various partners, including WHO, and the active participation of national partners, the Education Ministry, and water and sanitation.

A number of partnerships were struck at the international level as well. So, in the context of an integration fight against these illnesses we have been able to strengthen the national health system. Today, our national health system is much more flexible than it used to be because it has had to adapt to this new strategy. As regards the three illnesses that I mentioned, I can tell you that the health professionals played a very important role in implementing these strategies. Strong commitment and determination have been absolutely indispensable in the success of these programmes. Today, we are convinced that we have won a very important battle, maybe not a war, but a very important battle in the fight against these illnesses, including blinding trachoma in particular, malaria and schistosomiasis. We now need to make sure that the sustainability of these actions is guaranteed in the long term.

As regards the consideration of these results and the eradication or elimination of these illnesses, there are very mixed challenges we have to face; and we are going to rely on all our partners to come hand-in-hand with us to make sure that we will be able to overcome these obstacles. Interesting statements have been made relating to the vicious circle of illness and poverty, which has to be broken. In Morocco, the National Initiative for Human Development, launched by His Majesty Mohamed VI, aims at poverty alleviation, through small income-generating programmes targeting rural women, with literacy campaigns for women in rural areas, housing
programmes and actions to reduce drop-outs from schools.

We believe that this has been a useful platform in Morocco for advocating for the control of neglected diseases. We wish to make sure that we take on board the various partners, and we want to make sure that we take into consideration all the various aspects of these illnesses in an integrated manner. Of course, it is very difficult to transpose one experience in a country to another country. However, concepts that we have used can be adapted elsewhere, and the Kingdom of Morocco is certainly willing to share its experiences with other countries in the context of the South to South cooperation and cooperation with our friends in the North who, of course, have been very helpful. France, Belgium and Germany have been very helpful in the various programmes that we have launched over the past few years and we are perfectly happy to share this experience.

Brazil, Dr Jose Ricardo Pio Marins, Coordinator of Communicable Diseases, Secretary of Health Surveillance, Ministry of Health

In the name of the Minister of Health of Brazil I should like to express that the Minister of Health supports this very important initiative. Brazil is addressing more than 10 neglected tropical diseases, including those marked for elimination (leishmaniasis, filariasis, onchocerciasis, trachoma, leprosy, Chagas disease, dengue, cysticercosis and schistosomiasis). The challenges for our country to control these diseases are the same as in most developing countries. A lot of progress had been made in Brazil; for example, we are close to eliminating onchocerciasis, filariasis and diseases such as trachoma, leprosy, schistosomiasis, visceral leishmaniasis, dengue and Chagas diseases. However, foodborne diseases are increasing in our country, and probably in other countries in the world, and are posing new challenges.

The lessons learnt by us can benefit other countries also. For example, the researchers at Fiocruz developing drugs, the production of drugs and vaccines and laboratory tests for some diseases, and in other institutions like the Butan Institute with the anti-venoms and the snake bite surveillance, are some of the new technologies that we can share with others. Also, in Brazil, we are developing new tools to evaluate the elimination of filariasis. We now have just foci but can help other countries, especially in other countries where the disease is a big burden and where its control is impossible without a national surveillance system.

Brazil has a big surveillance system that covers the whole country. The National System for Communicable Disease Report allows us to control all outbreaks and monitor the trend of the diseases under control. This is a very important tool that we can share with other countries also.

Brazil, probably like other countries, also welcomes research partners, especially WHO, the Pan American Health Organization and other international agencies such as the Bill & Melinda Gates Foundation and other foundations and the pharmaceutical industry, to identify new possibilities for the production of drugs for developing country mechanisms, for developing new vaccines, new bednet kits and working with a perspective of a sustainable programme control.

This meeting can be the first step for a new era to achieve a new response for neglected diseases.

Egypt, Professor Wahid Doas, Director-General of Hepatology and Tropical Institute, Ministry of Health and Population

It is an honour and a privilege for me to be participating in this important meeting on behalf of the Egyptian Ministry of Health. Egypt has suffered from tropical diseases since ancient times. Evidence of schistosomiasis and filariasis have been found in the mummies of Egyptians dating to about 5000 years ago.

Egypt started its schistosomiasis control programme about 15 years ago. At that time, the incidence was about 20–35% of the population. The campaign depended on mass chemotherapy, snail control and a media campaign programme. Incidence is currently about 1.5%. Schistosoma haematobium has been almost eliminated in the Nile Delta. We hope that we can sustain our programme, although we have some concerns about the emergence of drug resistance to praziquantel. We also need more research in prevention, including the potential for vaccination. The large programme for the eradication of lymphatic filariasis has been a large success, with filariasis almost eliminated in many parts of Egypt.
Honduras, Ms Gracibel Bu, Minister Counsellor, Permanent Mission of Honduras to the United Nations and other International Organizations in Geneva, Switzerland

Honduras is under the category title of being a priority country of the Region of the Americas, under the umbrella of the PAHO/WHO and other international agencies. I would like to thank WHO for inviting my country to participate in this meeting. Honduras highly appreciates the statements given by the partners and agencies expressing their commitments made, including their future commitments on the neglected tropical diseases. We also highly appreciate the delegations who have taken the floor for sharing their experiences and challenges. Honduran authorities are aware that these diseases have enormous social and economic consequences, especially in developing countries. With new low-cost technology, sharing of information, global firms and global partners, we will be able to control and prevent these diseases.

Honduras continues on the process of social promotion and education to increase public awareness as well as building community initiatives in order to create an adequate environment and healthy lifestyle to all Honduran people. We have to highlight that international cooperation has played a key role in my country in order to control the neglected tropical diseases.

I would like to congratulate Dr Chan for her clear, sensitive and accurate report proposing the global strategy to fight the neglected tropical diseases and for her personal comments on the programme. We agree that we should no longer wait in order to cope with neglected diseases all over the world. I would like to ratify, on behalf of the Ministry of Health and the Spanish Agency for International Cooperation and my Institute, Public Health Institute Carlos III in Madrid, that we strongly support the WHO programme on neglected tropical diseases and will continue to support it in the near future.

Spain, Mrs Elena Madrazo-Hegewisch, Deputy Director of Multilateral and Horizontal Cooperation, Spanish Agency for International Cooperation

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Setting and agreeing the Millennium Development Goals may be among the most important political and health commitments worldwide. According to the WHO targets, the Spanish technical and financial cooperation is focusing activities right now on different geographical areas and activities as follows.

We are developing programmes on leishmaniasis in Afghanistan, Ethiopia Somalia and Sudan and in Latin American countries including Bolivia, Ecuador and Honduras. For African trypanosomiasis, we are developing programmes in Angola and Equatorial Guinea. We are working closely with Bolivia and Honduras on Chagas disease and with Equatorial Guinea concerning lymphatic filariasis.

Burkina Faso, Dr Uche Veronica Amazigo, Director, African Programme for Onchocerciasis Control

The community-directed intervention approach pioneered by the African Programme for Onchocerciasis Control (APOC) is unique and has proven to be highly promising in empowering communities, building trust and partnerships between health-care services, donation programmes, and communities and donors, and strengthening national health systems in the process. This strategy has made it possible for APOC to reach the world’s most impoverished communities in Africa where there are no roads, no doctors, no drugs, where health information is scarce and where need is greatest; that is where you find APOC projects in more than 19 countries in this region.

A recent study by the Special Programme for Research and Training in Tropical Diseases financed by the Bill & Melinda Gates Foundation has ably demonstrated the value of integrating all the health interventions, including malaria, into the APOC strategy using community-directed treatment using ivermectin involving communities. The trademark of APOC is giving power to the community. This is the secret of the success of the onchocerciasis control programmes. Medicines can be available, but the challenge is bringing medicines to those most in need: this is where APOC excels. APOC has demonstrated that by involving communities themselves you bring medicines and health services to the remotest
We are gathered here for a common agenda, and that common agenda is change. Change from neglected to recognition. The WHO Director-General talked about it as a turning point, and by turning point we mean that we are changing course. That means we have to think differently and we need to behave and act differently. In that spirit, I would request you all to join me in an exercise which is probably very unusual for this room. I hope you will all cooperate with me.

Please can you close your eyes now, all of you (10-second pause). You can open your eyes, thank you very much. How did you feel? Apprehensive? Concerned? Don’t know what’s going to happen next or when? Imagine extending that 10 seconds of closing your eyes to a minute, perhaps an hour. None of us in this room would desire to be in that situation. Yet, some 6 million people suffer from blindness every hour, every minute, every second of the day. In fact, their entire life is now being spent in darkness, and about 10 million people are at immediate risk of irreversible blindness from a bacterial disease known as trachoma.

In some neglected populations, trachoma is so common in children that blindness is taken as a fact of life. Women being the caretakers of children are, unfortunately, three times more prone to blindness than men. The International Trachoma Initiative is dedicated to the elimination of blinding trachoma in support of WHO’s Resolution 51.11. In the past six years since our inception, we have advocated and supported the implementation of the WHO-recommended strategy known as SAFE. I will not go into details because we do not have time, but you heard from the Honorable Minister of Morocco, the success story of trachoma in that country based on the SAFE strategy. That is a testimony to the power of partnerships and the SAFE strategy.

I want to be pragmatic here: we all talk about partnerships. We all talk about integration; but let me tell you, working together is not easy. Integrating our efforts needs patience, it needs perseverance, it needs hard work and it needs tolerance between each other. I want to address this integration at three levels. First, it is a fact of multisectoral integration, and that is the beauty of the SAFE strategy: it combines the clinical intervention with the surgery and antibiotics along with the preventive intervention of clean water and sanitation. That is something which we can build on and that is something which we cannot avoid if we are talking about sustainable development of communities.

Second is the integration of activities and synergies in service delivery; critical to the success that we have not addressed today is the involvement and engagement of communities. For example, will a chief in rural modern Ghana open the compound for conducting surgery in elderly patients who are unable to walk to the health clinics? How much better can we get with regards to decentralized services? We forget the role of the community and the leaders in the service deliveries.

Third, the concept and control of elimination and eradication of neglected tropical diseases is certainly not going to be addressed in the next five years. It is a long-haul philosophy. Towards the end game, identification of infections and control of epidemics and control of clusters need to be integrated into routine health services. At the same time, interventions on the prevention of diseases should be integrated into education systems, formal and informal. Promotion of hygiene through women’s groups and local associations; this is integration of the public systems.

In this era of public–private partnerships, ownership of the problem and shared responsibility for taking actions, whether it is the community, the government, civil society and private or international agencies, is the true answer to change and transformation. We are looking for transformed communities that are informed, educated and empowered. The International Trachoma Initiative is pleased to be a catalyst in the change process. We are delighted to work with our many partners who are gathered here today and by combining our places and to those most in need.

If this concept is widely adopted where feasible, it will certainly revitalize primary health care in Africa and bring services to control neglected tropical diseases to the poorest. The APOC community network of more than 350 000 trained community-directed distributors and volunteers could be used to strengthen the primary health care control for malaria and the neglected diseases. APOC is operating in more than 300 000 communities in Africa. The onchocerciasis control programme has been a pathfinder for the control of other neglected tropical diseases. It has pioneered a model for public–private partnership and the drug donations programme. We sincerely thank Merck & Co., Inc. for this great initiative.
First Global Partners’ meeting on NTDs

I want to say that this is the beginning of change. I look forward to working together with everyone with a new attitude, with a new mindset and in a spirit of collaboration. I want to leave you with one final reminder that as we are in the business and in the race against neglected tropical diseases, let us not neglect any partner who wants to be committed and to be with us.

UK, Professor Alan Fenwick, Director, Schistosomiasis Control Initiative

The Schistosomiasis Control Initiative was established less than five years ago at Imperial College in London with funding from the Bill & Melinda Gates Foundation. At that time there was very little schistosomiasis control going on in sub-Saharan Africa, and what we wanted to do was to demonstrate that, if given the resources, countries could control this disease, using chemotherapy delivery either to school-age children or whole communities, depending on the prevalence and intensity of infection using the WHO criteria. It did not take very long for this initiative to become an integration project, because it was immediately obvious that those people who had schistosomiasis also had intestinal helminthiasis, and so albendazole was added. Within two years we were able to support the country programmes and scale up at treatment in six countries – Burkina Faso, Mali and Niger in West Africa and Uganda, the United Republic of Tanzania and Zambia in East Africa. In 2006, almost 20 million people were treated in these six countries, demonstrating a very positive effect on reduced prevalence and intensity of infection.

We are a partner in the Neglected Tropical Diseases Control Programme funded by the United States Agency for International Development. We are a partner with WHO in all the countries in which we work, and this now numbers nine, and a partner in the Global Network. We are very proud to have had funding not only from the Bill & Melinda Gates Foundation but also from Geneva Global and from small, private donors. We have received drug donations and are distributing them from Feed the Children International. We have benefited hugely from MedPharm’s programme, which has utilized donations from the Canadian Humanitarian Trust to help people receive treatment for their parasitic diseases. I am very proud to be a member of this meeting but, interestingly, what I am missing by being here is, tomorrow Niger is launching its integrated neglected tropical diseases programme. Nobody can do it alone and we do not want to. We have all been working, not only with the partners I have mentioned but with the pharmaceutical industry who donate the needed drugs. I would like to thank Merck & Co., Inc. for adding to that list, but what we really want to do with all of us is to allow the countries to implement the programmes that they need to control neglected tropical diseases.

Médecins Sans Frontières, Dr Christophe Fournier, President of the International Council, Switzerland

We wholeheartedly support WHO action in addressing neglected tropical diseases and look forward to a greater commitment and opportunity to continue working with you in making some real achievements in this area of medicine. As you know, Médecins Sans Frontières has been involved for a very long time in treating patients affected by neglected tropical diseases. We have been very active in trying to improve the diagnostic and interpretative tools notably, but not only, for more than 20 years now for trypanosomiasis, sleeping sickness, kala-azar and, most recently, Chagas disease and Buruli ulcer.

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Although we can appreciate that advocacy and action for getting appropriate and affective tools is a lengthy process, we must do everything possible to shorten the time between the discovery of new tools and access for the patients who suffer in the meantime. The intention is there but is taking forever and takes an immense toll on our patients in the field. Médecins Sans Frontières is a co-founder along with the Pasteur Institut of the DNDi. We know that much more support has to be provided, especially in the area of research and development. Research and development is needed not only for getting new treatments but also new diagnostic tools. I will take two examples.
I am based at the Commission of the African Union in Addis Ababa where I serve and coordinate the Pan-African Campaign for the eradication of tsetse flies and trypanosomiasis. I would like to thank WHO for inviting me to this highly significant meeting and for giving me an opportunity to make a few remarks that are related to the cause and context of this meeting.

We at the African Union Commission applaud the great partnership of WHO with African countries in the struggle against diseases in general and the so-called neglected tropical diseases in particular. We are especially grateful to WHO, not only for its leadership in highlighting the need and urgency for addressing various health strategies but also for developing a global alliance through which the global obligation to contribute to the elimination of these diseases can be discussed and translated into tangible action.

In July 2000, the African Heads of State and the Governments in their summit in Togo, adopted the collective decision urging Member States of the African Union to embark on a Pan-African Tsetse and Trypanosomiasis Eradication Campaign, and assigned the task of initiating, co-ordinating, promoting and supporting the activities in the implementation of this decision to the African Union Commission.

We need to act right now to deliberately push these diseases back. The public health measures that are required to eliminate the scourge of these diseases in our time already exist. What is needed is the will, whether your intervention is the best on equity or ethics or health provision, the will is needed. The diseases, including trypanosomiasis, are known as neglected because they attract little attention, little budget and little action in spite of their declared and known importance as serious health and development issues. However, as a result of the PATTEC initiative, a new situation we believe has arisen on the African continent now. African countries are now ready to act against trypanosomiasis but many, are still inundated by so many other programmes and they need resources in terms of support.

In conclusion, the Commission of the African Union is grateful to all the partners, some of whom are represented here for their financial and technical support in the various forms of intervention in response to Africa’s problems and causes. Through the World Health Organization we would like to appeal to the partners to consider giving more priority to support trypanosomiasis elimination programmes because it is technically feasible to do so and it makes better economic sense to end this disease once and for all.
I would first of all like to thank, very sincerely, WHO and the Director-General, Dr Chan for having invited my country, the Democratic Republic of the Congo, to this very important meeting. I would like to apologize, on behalf of the Minister of Health of our country who, for reasons that were outside his control, was not able to come to Geneva for this very important meeting. I would also like to thank His Excellency the Vice-President of the United Republic of Tanzania for his congratulations of our country in the context of the efforts made to eradicate sleeping sickness in his country.

As you know, my country has experienced a long period of civil war that has seriously harmed the sanitary infrastructure of our national health facilities. Despite these difficulties over the past 10 years, the Democratic Republic of the Congo has made many efforts, thanks to the support of a number of partners including WHO, to implement plans for the control of neglected tropical diseases, in particular onchocerciasis, river blindness, lymphatic filariasis and guinea-worm disease. It has been said that a lot of work still needs to be done if we want to eradicate all the neglected tropical diseases in my country, but with the support of all the partners I would like to say that this is possible; and I would like to urge you to commit yourselves to the eradication of all of these diseases that harm our populations, not only in the Democratic Republic of the Congo but in other countries of the African continent.
“Together we are upholding a fundamental principle of health development, equity. Access to life-saving and health-promoting interventions should not be denied for unfair reasons, including an ability to pay. […] We must not forget: we are dealing with neglected populations as well as neglected diseases. These people usually live in areas not covered by formal health services, and are notoriously difficult to reach.

This is a population-wide approach: no one is excluded for unfair reasons. Nor is poor access to health services an absolute barrier. Many of these control strategies require only once-yearly contact with health services.

If we want improved health to work as a poverty-reduction strategy, we must deliver interventions to the poor. Here is where we frequently fail. Here is where greater innovation is needed. All the donated drugs in the world will not do us any good in the absence of systems for their delivery to those in need. […] I know you have found ways to use existing delivery systems, such as schools, in efficient and cost-effective ways.

Populations left behind by socioeconomic progress are in dire need of safe water and adequate sanitation, better access to health services, more opportunities for education, and improved nutrition. However, they also need to be freed from the burden of disabling and debilitating infectious diseases.”

Dr Margaret Chan
Director-General, World Health Organization
Report of the WHO Strategic and Advisory Group on Neglected Tropical Diseases

The Strategic and Technical Advisory Group on Neglected Tropical Diseases has an important responsibility as the principal advisory group to WHO concerning the control of neglected tropical diseases. Its mandate is to advise on global policies and strategies, ranging from research and development to delivery and linkages with other health interventions; and to assist in monitoring the implementation of control interventions against neglected tropical diseases.

The group currently has 21 members, each of whom is an expert and authority in some aspect of neglected tropical diseases, including case management, chemotherapy, epidemiology, public health and vector control. Many of these experts work closely with ministries of health in their home countries. This group is superbly qualified to undertake the mandate that has been set for its attention, and is most grateful for the support and expertise of staff at WHO in Geneva and in the Regions.

The group held an intense first meeting on 17–18 April 2007 at which WHO’s strategy for the control of neglected tropical diseases was presented. The strategy contains two components:

- preventive chemotherapy;
- innovative and intensified disease management, underpinned by vector control, veterinary public health, health education and environmental sanitation.

This novel yet practical approach to disease control stimulated the group to identify \textit{14 action points} for WHO’s attention.

1. The WHO \textit{ad hoc} Strategic and Technical Advisory Group (STAG) on Neglected Tropical Diseases accepts that its primary role is to offer objective advice to WHO based on critical review of the available evidence.

2. Endorses and welcomes the enlightened vision of the WHO Department of Control of Neglected Tropical Diseases as it seeks, with respect to human rights, to make a major contribution to the alleviation of poverty and the promotion of economic development based on (i) intervention packages by means of preventive chemotherapy and transmission control, (ii) the development of innovative and intensified disease management, and (iii) evidence-based advocacy for expansion of control of neglected tropical diseases (NTDs).

3. Gratefully acknowledges the important contribution of the pharmaceutical industry to the control of NTDs, and encourages WHO to give due and wider recognition to this fundamental and important commitment to human welfare.

4. Firmly believes that reduced disease burden and economic growth are intimately related, as emphasized in the Report of the Commission for Africa.

5. Encourages WHO and its Member States to expose more fully the importance of NTDs to global health, poverty alleviation and economic development wherever appropriate, and in particular at the G8 meeting in 2008 in Japan, given the influence of this meeting on resource allocation, policy formulation and furthering the human rights agenda.

6. Proposes that WHO should seek opportunities to engage in discussions with the pharmaceutical industry concerning NTD control, particularly regarding the possibility of expanded donations and logistic and operational capabilities for delivering health care where NTD control is in progress.

7. Stresses the importance of advocacy for NTD control by publicizing successes such as the increased effort towards the eradication of dracunculiasis and onchocerciasis and of other such programmes that have secured better health for millions of poor people, as well as the remaining important challenges including morbidity and disability control.
8. Expresses concern at the dwindling lack of expertise and training in vector control given that so many NTDs are vector-borne and that for some NTDs vector control is the sole option.

9. Encourages WHO to support increased, quantitative, health-economic analysis given its importance in policy formulation and resource allocation for NTD control.

10. Firmly endorses the close linkages between successful interventions for NTD control and research in methodology, innovation in delivery, and accurate surveillance and evaluation. Emphasis on the importance of supporting operational research should be made to governments and funding agencies in addition to the need to support discoveries in biomedical research.

11. Requests that WHO appoints at least two more experts to the STAG to cover the high importance of health economics and zoonotic diseases as these relate to NTDs.

12. Recommends that WHO establishes a STAG working subgroup to devise procedures for monitoring the impact of packaged interventions for the control of NTDs.

13. Encourages WHO to incorporate the control of NTDs into the health agendas of regional, subregional and national economic forums.

14. Encourages the exploitation of the opportunities presented by integrated packages for NTD control to strengthen health-care systems in poor countries.

The WHO Special Programme for Research and Training in Tropical Diseases has identified five areas of research activity that will support NTD control, provided the necessary investigations can be undertaken with adequate funding.

- Burden and economic impact of neglected tropical diseases;
- Pharmacovigilance and surveillance;
- Epidemiology and public health;
- Health economics and comparative cost and cost effectiveness;
- Interactions of NTDs with HIV/AIDS, malaria and tuberculosis.

The STAG is determined to work to reduce the burden of neglected tropical diseases and to stimulate socioeconomic development.
United States Centers for Disease Control and Prevention, Dr Mark L. Eberhard, Director
of Division of Parasitic Diseases, USA

The United States Centers for Disease Control and Prevention (CDC) and WHO were the
two founding partners that laid the foundation for, and spearheaded, the global eradication of
dracunculiasis. Other organizations, most prominently The Carter Center and UNICEF,
have picked up the cause but now it falls again to WHO to provide the last mile of
surveillance, containment and certification to complete the task. The Division of Parasitic
Diseases is committed to continuing as a WHO Collaborating Centre and to conduct
programmatically relevant research in support of dracunculiasis eradication. We are also
committed to work with WHO on issues such as surveillance and certification to achieve this
final goal, making dracunculiasis only the second infection to be eradicated, globally.

Drugs for Neglected Diseases Initiative, Dr Bernard Pecoul, Executive Director,
Switzerland

Where tools are available to achieve success they should be used. However, existing tools are
not always satisfactory.

It is in this context that the Drugs for Neglected Diseases Initiative was launched in 2003. Its
partners and founding members – the initiative’s research institutes in India, Kenya and Malaysia,
the Pasteur Institut and Médecins Sans Frontières – have launched an initiative to develop 6–8
new treatments in the next 10 years.

New tools will allow us to determine our priorities and stimulate research at various stages, not only
at an early stage but also at a clinical stage, to also establish rules on intellectual property
and to examine perennial sources of funding. In this way, tools will be able to be used in an
appropriate manner for those who suffer from the neglected tropical diseases.

Helen Keller International, Dr Chad MacArthur, Director of Training and Community
Education, Director of Trachoma, USA

Helen Keller International is a leading technical assistance organization dedicated to preventing
the causes and consequences of blindness and malnutrition in order to improve the survival,
health and productivity of disadvantaged and vulnerable populations. Among those vulnerable
populations are those afflicted by neglected tropical diseases. Helen Keller International has
long been involved in the control and elimination of blinding diseases such as onchocerciasis
and trachoma and, through our onchocerciasis programmes, more recently in the control of
lymphatic filariasis. In support of our nutrition programmes and, particularly, in support of our
school health programmes, we are now involved in the control of soil-transmitted helminthiasis.

We are committed to the control of neglected tropical diseases using a comprehensive strategy
that includes mass drug administration, hygiene, sanitation, education, behaviour change
and morbidity management. This approach is reflective of the SAFE strategy used for the
control and elimination of blinding trachoma. As an organization, we have learnt that although
our programmes produce the desired results independently, their power is increased when
programmes are woven together, integrated and done in partnership with other nongovernmental
organizations, international, national and local academic institutions, the private sector including
the pharmaceutical companies and, particularly and most importantly, the governments that host
us in their countries.

By integrating our various blindness prevention and nutrition programmes we are able to multiply
our ability to save the sight and lives of those that most need it.
Institut Pasteur, Professor Marcel Hommel, Medical Director, France

Institut Pasteur, with an international network of 30 institutes worldwide, has long been committed to the fight against neglected diseases and is ready to support this new global initiative of WHO.

The Institut was one of the six founding organizations of the drugs for neglected diseases initiative and has much to offer the research arm of the neglected diseases initiative given our unique mix of experience at both ends of the spectrum. In the field, in the countries where neglected diseases exist, we have well-established laboratories, sometimes in situations where no other modern laboratory facilities exist and where we can intervene directly. At the other end, the high-tech end, we can contribute substantially to fundamental research to advance this field.

We are aware that there is still a lot to be done. Allow me to give you a few examples of things that we have been doing recently. The Institut Pasteur in Paris has established new units on African trypanosomiasis, Chagas disease and Buruli ulcer and the leishmaniasis and vector biology units have been strengthened.

The new Institut Pasteur in Korea, although only a few years old, is already at the cutting edge of technology, where innovative high imaging techniques are used to screen for new drugs against trypanosomiasis, leishmaniasis and tuberculosis.

Ivo de Carneri Foundation, Dr Alessandra Carozzi de Carneri, President, Italy

The Ivo de Carneri Foundation is an Italian foundation established in 1994 whose name derives from the Italian parasitologist who dedicated his life to neglected tropical diseases. It believes that successful interventions for the control of tropical diseases need well-equipped local infrastructure and properly trained personnel.

To this end, in collaboration with the Minister of Health of Zanzibar, a public health laboratory was built on Pemba Island, Zanzibar, in 1997 and has been operational since 2000. The laboratory has four essential components: (i) strategic operational research, (ii) advanced education and training, (iii) monitoring of endemic diseases and control programmes and (iv) anthelminthic efficacy. Since 2005, it has been recognized as a WHO Collaborating Centre for the control of schistosomiasis and intestinal parasitic infections. The establishment of this laboratory would not have been possible without the cooperation of the Ministry of Health of Zanzibar.

The foundation also supports local capacity-building as an essential means of developing skills and encouraging the autonomy and sustainability of developing countries with trained and competent local staff. To this end, the foundation promotes training courses in tropical medicine and international health using a public health approach based on the development of managerial competences in addressing the control of endemic neglected tropical diseases. Among those, the foundation is committed to the organization of a training course for African programme managers on the integrated control of helminthiasis with preventive chemotherapy in collaboration with the WHO Department of Control of Neglected Tropical Diseases and the WHO Regional Office for Africa.

Médecins Sans Frontières, Dr Christophe Fournier, President of the International Council, Switzerland

Médecins Sans Frontières wholeheartedly supports WHO’s actions in addressing neglected tropical diseases and looks forward to greater commitment and opportunities for collaboration to make some real achievements in this area. For a very long time Médecins Sans Frontières has been involved in treating patients affected by neglected tropical diseases. For more than 20 years it has been highly active in attempts to improve diagnostic and interpretative tools, most notably for trypanosomiasis, sleeping sickness, kalaazar and, most recently, for Chagas disease and Buruli ulcer.

Advocacy and action for getting appropriate and effective tools are lengthy processes, and everything possible must therefore be done to shorten the time taken between the discovery
The Global Alliance to Eliminate Lymphatic Filariasis is a partnership that supports the global programme which is embedded in the strong relationship between the ministries of health and WHO to alleviate the suffering of affected populations. Lymphatic filariasis is one of the most disabling diseases. It is endemic in some 80 countries, with 40 million people grossly disabled or deformed by lesions that stigmatize communities, individuals and families. Some 120 million people are estimated to be affected, with 1.3 billion individuals at risk. Given the availability of simple and cost-effective public health interventions, such a situation should no longer exist. Several countries including China have arrested this disease and its transmission in China in an affected population of 350 million.

The lymphatic filariasis programme has upscaled rapidly during the past few years from its inception in 2000, when 12 million people were treated, to 2005 when globally 381 million people were treated with antifilarial drugs to reduce the risk of transmission. This is probably the most rapid up-scaling of a public health programme currently in the world. Of the endemic countries, 42 now have active programmes and are committed to the elimination of the disease.

Egypt, following the WHO-recommended strategy, has demonstrated that the parameters of success, defined by the absence of transmission, have been fulfilled in a population of 2.5 million people in the Nile Delta since 2005 when the programme started through six rounds of mass drug distribution. In sub-Saharan Africa, significant progress has been made using the Mectizan®/albendazole combination for control and elimination. This intervention provides an umbrella for assisting not only the cessation of transmission of filariasis but also for control of onchocerciasis and intestinal worms. Elegant studies from both east and west Africa document the effectiveness of the drug combination.

In Burkina Faso, 10.4 million people have benefited from Mectizan®/albendazole over the past two years. The cost of this intervention was calculated to be US$ 0.6, or six cents per person treated per year, with funds largely provided by the government itself. The impact has been that filariasis has been stopped and the previous huge investment in the onchocerciasis control programme has been protected and the control of intestinal worms is in progress. The power of Mectizan® also extends to its effect on scabies, and where it has been given this disease no longer exists. In Burkina Faso, annual treatment by communities managed through the health system, has been a remarkable and sustained success.

Despite these achievements, which have been stimulated by the generous donation of albendazole and of Mectizan® by Merck & Co., Inc., in Africa many challenges remain. One such challenge – integrated control – has been partially resolved at this meeting thanks to the generosity of Merck KGaA Germany in providing praziquantel. For these diseases in Africa now, there is no drug which is not donated.

In Asia the challenge is different because diethylcarbamazine (DEC) is required for up-scaling. DEC is probably the cheapest drug on the planet: 1000 tablets cost US$ 3–4, which is sufficient to treat approximately 300 people. A drug fund representing approximately US$ 6 million annually is needed to provide high-quality DEC for the remaining populations in Asia. This would lever in donated albendazole with its important ancillary impact on intestinal worms. In order for integrated control to up-scale in Asia, the regular provision of high-quality DEC...
The Global Network recognizes that the available drugs do not target all of the neglected tropical diseases. Measures therefore need to be stepped up urgently to conduct research and development for new control tools, new drugs and new diagnostics. This agenda also includes the new vaccines for neglected tropical diseases; anti-poverty vaccines as we call them. Several such vaccines are under development and clinical testing, including a new vaccine for leishmaniasis, a new vaccine for schistosomiasis. Our own hookworm vaccine, which is under development by the Sabin Vaccine Institute, is now in clinical trials in Brazil. To increase global two years after the first signs of the disease occur. Less poor families, the middle-income families, seek treatment after two months. As a result, in the poor communities the symptoms become irreversible in poor people. Physical disability restricts the quality and the type of work people do, leading to impoverishment. It reduces the capacity to work and the costs to access care are not affordable by the poorest.

What western society would tolerate 25% or more of its adult male population suffering gross genital lesions and not being provided with access to surgical care? Remember we can stop this happening for a sum as trivial as six cents. Disability management by simple hygiene measures is poverty reduction actually in action. Women can now walk to market, fetch water for themselves and their families and no longer be socially and economically isolated. That is not a bad return for six cents per person per year.

If we cannot deliver drugs free of charge once a year to the poorest populations at a trivial cost, there is not a great chance of doing much else in public health.

Sabin Vaccine Institute, Professor Peter Hotez, President, USA

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Swiss Tropical Institute, Dr Marcel Tanner, Director, Switzerland

The Swiss Tropical Institute is ready to continue and strengthen its commitment to research and control of neglected tropical diseases at the level of innovative new tools, validation of such tools and the application of the validated tools into large-scale public health practice.

Research and control of neglected tropical diseases are part of its mandate, and the Swiss Tropical Institute is therefore happy to join these renewed and concentrated efforts to contribute to alleviate the unacceptable burden of these diseases. Its commitment will be reflected in many of areas such as schistosomiasis, trypanosomiasis, intestinal helminthiasis and food-borne trematodiases. These efforts will complement the Institute’s strong and traditional involvement in research and control of malaria, TB and HIV/AIDS. It will specifically focus on and strengthen the partnership with the countries with which traditional links and productive collaboration have been maintained for decades in Africa and Asia.
First Global Partners’ meeting on NTDs

RTI International, Ms Mary Linehan, Deputy Director of NTD Control Program, USA

In 2006 the United States, through a major new effort funded by the United States Agency for International Development, started a worldwide initiative for control of neglected tropical diseases. The NTD Control Program represents a large new investment and commitment to support the scale up of integrated NTD control programs. Through this five-year effort, over 40 million people will be reached with 160 million treatments.

RTI International is very pleased to be leading this important new USAID funded program and we are working in close collaboration with the WHO, major pharmaceutical donation programmes and with partner organisations such as LATH, ITI and SCI.

This year we are providing support to five African countries which include Burkina Faso, Ghana, Mali, Niger, and Uganda. At their request, we are assisting them to plan and coordinate various in-country NTD control resources and to implement the scale up of integrated treatment and service programs.

Through the NTD Control Programme we will also provide grants for NTD treatment programmes in up to 10-15 new countries. In this way, we will be able to respond to the needs of more countries, and engage new implementing partners in the effort to control NTDs through integrated treatment and support.

A major purpose of the NTD Control programme will be to assist our country partners in demonstrating that large numbers of people can be treated at low cost. We will work with country leaders to document the best ways to achieve programme efficiencies though integrated approaches. And as we work in close partnership with ministries of health to help build the local capacity to assure that programmes will be responsive to local need and be sustainable.
“Gathered in this room are scientists […] political leaders and ministries of health […] development agencies, foundations and implementing agencies […] Industry is present […] WHO also has an important responsibility. In our role as the leading technical authority on health, we can set the control strategies and define best practices. This is one way to better align the work of partners with international standards, strategies, and recommended practices.”

Dr Margaret Chan
Director-General, World Health Organization

Listed below are some of the partners who have donated medicines through various projects. Extracts from their speeches can be found in the various sections of this report.

- Bayer HealthCare
- GlaxoSmithKline
- Johnson & Johnson
- MedPharm
- Merck & Co., Inc.
- Merck KGaA
- Novartis
- Pfizer Inc
- sanofi-aventis
Denmark, Dr Assia Brandrup-Lukanow, International Public Health Adviser to the Health Metrics Network

In all of this work [Germany’s priority in development cooperation in health] the partnership with WHO plays an important role in ensuring that the interventions follow the international standards and recommendations and are evidence-based. Germany, therefore, is also supporting the WHO Special Programme for Research and Training in Tropical Diseases in its work to strengthen research capacity in partner countries as one contribution to improving the knowledge base on neglected tropical diseases. A number of research institutions and universities from Germany and their network, the Society for Tropical Medicine, are cooperating closely with WHO programmes through secondments and sharing of expertise and research. The contributions to the onchocerciasis and schistosomiasis control programmes are examples of previous commitments.

Bill & Melinda Gates Foundation, Infectious Diseases Global Health Program, Dr David Brandling-Bennett, USA

The Foundation is very fortunate to have large resources to achieve its objectives and goals but realizes that even with these substantial resources success cannot be achieved unless they are targeted. For this reason, the Foundation is strategic in its actions and builds partnerships in order to accomplish its goals. The Foundation acknowledges that this work cannot be accomplished alone and actively seeks partnerships as a positive indication of the value of its investments. The commitment of governments, multilateral organizations, nongovernmental organizations, the private sector including the pharmaceutical industry and other foundations, both in technical and financial terms, is therefore critical for the Foundation.

Nongovernmental Development Organization (NGDO) Coordination Group for Onchocerciasis Control, Dr Adrian Hopkins, Former Chairman, UK

The Nongovernmental Development Organization Coordination Group for onchocerciasis control was formed in 1992 by various partners who were working closely with WHO to eliminate onchocerciasis as a public health problem. Most but not all of these activities were concentrated in the countries not yet in the control programme in West Africa and in Central America. Membership of the group includes Christoffel-Blindenmission; Helen Keller International; Interchurch Medical Assistance; Light for the World; Lions Club International Foundation; Mectizan Donation Program; Mission to Save the Helpless; Organisation pour la Prévention de la Cécité; The Carter Center; Sight Savers International; the United Front Against River Blindness; the United States Fund for UNICEF and the Charitable Society for Social Welfare.

The Group has been exploring ways to integrate and co-implement activities since its inception. Many of these programmes are based around nongovernmental development organizations concerned with eye care and have been integrated into Primary Eye Care from the beginnings in 1990s. Over the past decade, other members of the Group have been active in distribution of vitamin A, control of lymphatic filariasis and mass distribution of praziquantel for schistosomiasis as well as distribution of insecticide-treated mosquito nets.

In September 2006, the Group held a joint meeting with the lymphatic filariasis network, which was well established at WHO in Geneva. This meeting proved so successful that it was decided to expand representation at the next meeting and to hold it in Oak Brook, Chicago, USA. The May 2007 meeting included representatives not only from lymphatic filariasis control programmes but also from trachoma and schistosomiasis initiatives, together with representatives from USAID and the Global Network for Neglected Tropical Disease Control.
Non-governmental organizations play a critical role in the successful implementation of programmes to control neglected tropical diseases worldwide.

Three years ago, the First Lady of Ecuador represented Central and South America as the keynote speaker at the annual meeting of the Partners for Parasite Control held at WHO headquarters. The First Lady outlined the achievements of an Ecuadorian nongovernmental organization – the National Institute for Children and Families – that, with MedPharm’s support over the past decade, has grown from treating 500,000 children with intestinal parasites to treating 2 million children. This highly successful programme is now identified as a people’s programme, with ownership firmly at the grassroots level. Every presidential candidate in the past three elections has recognized this Institute and promised to expand de-worming programmes. More recently, a national committee has engaged the relevant national (MOH, MOE, MOSA) and international (PAHO, WFP, UNICEF) groups in the formation of a nationwide programme to treat every child and family member. Thanks to Canadian friends and donors, MedPharm has increased its commitment from a donation of 6 million mebendazole tablets (500 mg) last year to 10 million tablets in 2007. For the treatment of intestinal parasites, this is the most significant programme in the Americas. It began as a nongovernmental organization initiative and continues under local leadership.

In Zambia, I recently visited both the Schistosomiasis Control Initiative and a de-worming programme led by RAPIDS that currently receives from MedPharm mebendazole and albendazole plus vitamin A sufficient to treat 1 million children. RAPIDS is a consortium of five major American nongovernmental organizations, CARE, CRS, AFRICARE, the Salvation Army and World Vision International. While its original goal was to address the needs of people living with HIV/AIDS, the programme’s success has attracted millions of dollars of grants from USAID and is now positioned to expand into other critical health sectors such as malaria. What impressed me was the effectiveness of their delivery systems and the depth of their coverage. RAPIDS has over 12,000 Zambian dedicated volunteers and village outreach personnel who daily travel to the most remote villages. RAPIDS recognized the link between its target group and the broader need to improve their nutritional status and to introduce vitamin A and de-worming. Now a dialogue is under way between the Schistosomiasis Control Initiative and RAPIDS to find synergies in their work. The national director of RAPIDS, Bruce Wilkinson of World Vision International Zambia, is often cited for his outstanding leadership and is to be honoured on World Malaria Day by President Bush in a Rose Garden ceremony at the White House. When I met with Bruce we discussed increasing the programme to treat 2 million people with intestinal parasites in 2007 year and to expand treatment to 3 million people next year.

These examples demonstrate the critical role of nongovernmental organizations in the successful implementation of programmes to control neglected tropical diseases worldwide. MedPharm hopes that the WHO programme will recognize its significant function in the delivery of effective programmes worldwide.

MedPharm, Mr Andrew Koval, President and Chief Executive Officer, USA

The Group fully supports this initiative within the global community to continue to expand this programme and take the “neglect” out of neglected tropical diseases.
Commission of the African Union, Pan-African Tsetse and Trypanosomiasis Eradication Campaign, Dr John Kabayo, Coordinator, African Union Headquarters, Ethiopia

The Pan-African Tsetse and Trypanosomiasis Eradication Campaign (PATTEC) Co-ordination Office was established in Addis Ababa and focal points were identified in all affected countries. Countries were invited to develop their national strategies and plans of action on how the eradication of trypanosomiasis would be implemented. Because trypanosomiasis is a trans-boundary disease, countries that share a common tsetse belt met under the auspices of the African Union to develop modalities of cooperation with partners of African countries in the war against trypanosomiasis.

Most countries have now developed their national plans and trypanosomiasis aggression proposals in harmony with a common PATTEC plan of action. Some countries, like Botswana and Namibia, have gone ahead and executed these projects, and the two countries are now believed to be free of trypanosomiasis transmission. Now other countries like Burkina Faso, Ethiopia, Ghana, Kenya, Mali and Uganda have borrowed money from the African Development Bank to initiate activities to eradicate tsetse in their countries.

For the first time – and probably for the first time in the history of the fight against this disease – African countries are now able to effectively use whatever support is available in their efforts to eradicate trypanosomiasis. Well-defined and properly costed project proposals for the eradication of trypanosomiasis have now been prepared to address the disease in specific areas in different countries. They are prepared and they are ready for support. The war against trypanosomiasis is now on and Africa is ready for the support that we will need from our partners.

United States Agency for International Development, Dr Irene Koek, Chief, Office of Health, Infectious Diseases Division, USA

The United States Agency for International Development is committed to the control of neglected tropical diseases. For a number of years it has worked with the African Programme for Onchocerciasis Control and The Carter Center on dracunculiasis eradication and with lymphatic filariasis control programmes. In 2006, thanks to the United States Congress, the Agency was given increased funding to start a programme on integrated control of neglected tropical diseases. Consequently, in September 2006 the Agency awarded a five-year US$ 100 million grant to a coalition of partners led by the Research Triangle Institute working in partnership with the Liverpool Associates in Tropical Health, the Schistosomiasis Control Initiative and the International Trachoma Initiative and with WHO and a number of other partners.

This represents an extraordinary and exciting opportunity to make the best use of these resources and to make a real difference at the country level. Programme activities have begun in five countries (Burkina Faso, Ghana, Mali, Niger and Uganda) where partners work on the ground and with the Schistosomiasis Control Initiative and the International Trachoma Initiative. At the same time, beginning this year for an award in 2008, a companion grants programme is being established to which other organizations in other countries can apply. This companion programme will be expanded beyond the initial five programmes. This is an exciting opportunity that provides a means of accelerating, with increased resources, the integrated approaches to mass drug administration for some of the key neglected tropical diseases.
“Political leaders and ministries of health in endemic countries are present, demonstrating the level of commitment to diseases that almost exclusively affect poor and powerless people. […] Our mandate must come from ministries of health. It is good to have so many health ministers present in this room and to know that these diseases are receiving priority.

Conditions of poverty perpetuate these diseases, while the health impact of these diseases perpetuates poverty. This strong association with poverty is readily apparent from just a few examples. Some forms of African sleeping sickness and leishmaniasis are 100% fatal if not detected and treated in time. All of the other diseases debilitate, blind or maim, permanently curtailing human potential and impairing economic growth.

This clear association with economic burdens has proved important in a climate of international commitment to poverty reduction. It has given these diseases an added dimension, and it has elevated their standing on the development agenda.”

Dr Margaret Chan
Director-General, World Health Organization
United Republic of Tanzania, Honorable Dr Aisha Omari Kigoda, Deputy Ministry of Health, Ministry of Health and Social Welfare

There is literature to suggest that the control of neglected tropical diseases is the best buy in public health. When I first saw this statement I was slightly puzzled by it but later on, after putting it in the context of my country, I realized that it was indeed true. So, what are the gains from focusing on neglected diseases? These include freeing people from the debilitating effects of lymphatic filariasis and onchocerciasis, resulting in increased productivity and social well-being. Studies of improved nutrition in schoolchildren following deworming resulted in enhanced growth and improved educational performance. Improvement for pregnant women in respect of anaemia … the list is endless. I also recognize that by tackling the neglected diseases we are directly addressing the Millennium Development Goals. It goes without saying, therefore, that the gains from focusing on these diseases are great and ones that we, as the least developed countries, cannot overlook.

African Programme for Onchocerciasis Control, Dr Uche Veronica Amazigo, Director, Burkina Faso

We Africans have the hope that the Millennium Development Goals will be achieved and that our continent will soon be rid of onchocerciasis. We hope too that neglected tropical diseases will be successfully controlled. Those who have hope have everything. It is up to all of us gathered here today to do our utmost to see that that hope is realized.

United States Centers for Disease Control and Prevention, Dr Mark L. Eberhard, Division of Parasitic Diseases

The burden of neglected tropical diseases has long fallen on the poorest and most vulnerable populations, and for too long these diseases have remained neglected, even by some of the very agencies that are looked upon to be leaders in this fight. The disabilities caused by these diseases contribute to keeping families and communities at economic and cultural disadvantage. However, broad partnerships among many visionary groups are making dramatic inroads against these, once seemingly hopeless, diseases. Partners will draw inspiration and our own commitment will be strengthened based on the strong support evidenced by Dr Chan and other dignitaries. It is truly an exciting and historic juncture in the fight against neglected tropical diseases.

DBL, Centre for Health Research and Development, University of Copenhagen, Dr Jens Aagaard-Hansen, Senior Researcher

In addition to research on neglected tropical diseases, the Danish Bilharziasis Laboratory (DBL) has always had a strong focus on capacity strengthening in the disease-endemic countries—with regard to both control and research. Thus, many of the resource personnel that are presently involved in this initiative have been trained by DBL. It was therefore especially warming that the Minister of Health for Uganda recognized the impact of our work over the years.

As a social scientist I will take the opportunity to highlight the importance of sociocultural and economic factors. Notwithstanding the importance of medical research to develop new tools in terms of pharmaceuticals and diagnostic tools, social determinants inevitably play a crucial role for the success of our endeavour. More particularly, we need country-specific knowledge of (i) the vulnerable groups without access to the control programmes (e.g. based on gender, poverty, ethnicity, migration patterns or occupation); (ii) continuous monitoring of adherence to control programmes in order to trace signs of “fatigue, incompatibilities and rumours” that may threaten the long-term success
Food and Agriculture Organization of the United Nations, Dr Katinka De Balogh, Animal Health Officer

We would like to thank WHO for this opportunity and also express our support to this important initiative. The Food and Agriculture Organization of the United Nations also has subscribed, as have other United Nations Organizations, to the Millennium Development Goals, and fighting poverty and hunger is one of our remaining aims. We also support the effort to control zoonotic and food-borne diseases, and it is in these areas that we see our role in assisting the initiatives to combat neglected tropical diseases. We are concerned that rabies, echinococcosis, cysticercosis, brucellosis, anthrax and tuberculosis should receive attention; they all contribute to human suffering and great losses in animal production.

Bill & Melinda Gates Foundation, Infectious Diseases Global Health Program, Dr David Brandling-Bennett, USA

The Foundation operates on the basis that every life is of equal value and that every person should have the same opportunity to live a healthy and productive life, no matter where they were born or where they live.

The Foundation thanks WHO and each and every one of you who is involved in these efforts. Your continuing engagement will be a necessary ingredient if the Foundation is to make future investments in these diseases, which unfortunately remain at risk of being neglected. With your support we do have a chance to achieve a dream that many of us have had for years: that these diseases will no longer be the cause of suffering, stigma and poverty, which has been their hallmark for centuries.

Nongovernmental Development Organization Coordination Group for Onchocerciasis Control, (the LF Network and the International NGDO Group for Trachoma Control), Dr Adrian Hopkins, Former Chairman, UK

“One of the added values of working with nongovernmental organizations is our ability to work very closely with governments and to work in difficult circumstances, sometimes in areas where work is very challenging because of political instability. For example, in 2006 one of our projects in the Democratic Republic of the Congo treated 3 790 000 people with ivermectin, almost 1 million people with vitamin A and 770 000 with mebendazole; it also identified 300 cases with cataracts. That is the sort of thing that the nongovernmental organizations can do in the field. Our members have been committed to integration for many years.

We have been doing it, we are still doing it, we will continue to do it. What we want to see and what we fully support is taking the neglected out of the neglected tropical diseases.
In the early 1950s, the Institut de Recherche pour le Développement (IRD) began research on neglected tropical diseases, in particular on human African trypanosomiasis and onchocerciasis, diseases for which research was concentrated on vector ecology, disease epidemiology and the improvement of control methods. The Institut was associated with the African Programme for Onchocerciasis Control from its creation in 1995 and has fully contributed to the preparation, launching and execution of the Onchocerciasis Control Programme in 19 African countries that had not yet benefited from disease control in western Africa. The Institut has participated in the Forum d’Action Commune since the creation of the African Programme.

The Institut is currently continuing its support to research of human African trypanosomiasis and onchocerciasis and has expanded its research work to other neglected diseases including American trypanosomiasis, leishmaniasis and filariasis.

This research work concentrates mainly on understanding the mechanisms of origin of pathological phenomena, the biological and ecological characteristics of vectors, the interactions of host–vectors–parasites and the study of relations between ecological and human factors; this approach will help to identify the variables indicating risk of disease. Research also concerns the identification of new molecules with therapeutic and vaccine potential, in particular the preparation and testing of a canine vaccine for visceral leishmaniasis that would indirectly diminish the risk of transmission of the infection to humans.

Objectives for 2006–2009 include research into the emerging infectious diseases and some of the neglected diseases, as one of six scientific priorities.

Finally, in the framework of the Agence Inter-établissements de la Recherche pour le Développement for which the Institut has been given management, the Institute will do its best to improve knowledge for the control of these diseases.

UNICEF–ESARO, Dr Robert Davis, Kenya

UNICEF brings to this global effort decades of field experience in child survival activities. Our commitments in this area started with control of yaws, tuberculosis and malaria control in the 1950s and 1960s, and with the Expanded Programme on Immunization since its creation in 1974, with renewed commitments to RBM in the current decade. We have also worked on guinea-worm disease and trachoma in many countries. We continue to work with communities, WHO, nongovernmental organizations, governments and bilateral partners in accelerated child survival with the special focus on Child Health Days and outreach as delivery platforms for high-impact interventions on nutrition and health.

Our geographical focus is on the developing countries, especially sub-Saharan Africa where more than one third of our programme funds is spent. Our institutional strengths are in programme communication and social mobilization, in procurement and supply management as well as in local level service delivery where we are a partner in, among other things, vaccination, malaria control and control of soil-transmitted helminthiasis.

We are a field-oriented organization with offices in more than 120 countries. Our commitment to the health-related Millennium Development Goals means that we are broadening out from a disease-specific orientation towards creation of structures for reaching those currently inaccessible with a package of high-quality interventions to accelerate progress in reaching the Millennium Development Goals, especially reductions in under-five mortality (Goal 4; Target 5).
It is clear from this meeting that differences are already being made in terms of controlling the neglected tropical diseases. We have heard from several countries about how they are taking the lead in addressing these issues, but it is also remarkable to hear how the private sector has contributed through the drug donations. Indeed, it seems almost as though the pharmaceutical industry has played a really central role in ensuring that control of these diseases remains on the agenda; and it is extraordinary to hear how new donations are still being made at this time.

There has been an extraordinary and, one hopes, welcome rise in public and private development assistance for health. In 2000, US$ 6 billion was available for development assistance. In 2005 that figure had more than doubled to US$ 13 billion. As we are all aware, much of this money was earmarked for particular activities, and the big three diseases have been mentioned several times today. So a real change has occurred not only in the availability of financing but also in the way in which it is directed and made available. This has made a big difference to the way in which countries have reflected on the role of the World Bank, and on their demands from the World Bank for support. It has also initiated a process of reviewing the Health, Nutrition and Population Strategy within the World Bank for which an update is provided below.

A process of consultation with countries and partners has been ongoing and is still continuing. Although the strategy has been approved by the most senior Development Committee it has yet to be approved by the Board. So, any comments, any feedback that you may wish to offer would still be timely and, indeed there is a dialogue going on right now in the spring meetings to address that. But the key message from the strategic direction is that priority will now be given to a focus on strengthening health systems and a focus on results: results in this sense meaning health outputs, health outcomes, health system performance, healthy system sustainability and preventing poverty due to illness. That does not mean that there will no longer be priority diseases but it does imply that a key role will be looking for synergies between health systems and disease priorities.

There is also a focus on the comparative advantages of the World Bank, and two areas will be mentioned. One is the economic analysis and the assessment of fiscal space, an issue that has been increasingly raised; the other is intersectoral work recognizing that health is not due to one single sector.

The final issue on the new strategic direction is establishing a collaborative division of labour among the partners or with the partners in the World Bank. What are the implications of that for the neglected tropical diseases? I think there are two issues that are worth addressing.

Over the next 12 months there will be a specific dialogue with WHO and with other partners to agree on collaborative divisions of labour on disease in general. That should include the neglected tropical diseases, which would provide an opportunity to position programmes for their control within health system priorities and to address this issue of neglect.

The issue of intersectorality in terms of the new strategy deserves special mention. Education and schoolchildren must be emphasized. In the early days of addressing the neglected tropical diseases it was the remarkably low cost of school-based delivery plus the high returns on improving both health and education that first caught people’s attention to this development area.

So, the issue of addressing some of these intersectoral approaches to dealing with these diseases is one that now perhaps should be given greater prominence. It is already the situation, if one looks at sub-Saharan Africa, that some 27 countries have in place plans for and arrangements for collaboration between the health and the education sectors to deliver school health, and these will provide opportunities for addressing the neglected tropical diseases, especially schistosomiasis, trachoma and intestinal helminthiasis. What many of us in the health side have tended to overlook is that, as the same time as funding has increased in the health dimension, it has also increased significantly in the education sector. The Education For All Initiative launched in 2000 is now seen by many as the Millennium Development Goal most likely to be achieved, and has received significantly increased funding from development partners.

So, there are now opportunities for increasing the availability of resources from the education side to support these kinds of education interventions. One of the key messages here is that the so-called fast track initiative of Education For All, the major source of financial resources for the education sector, has specifically identified school health and nutrition as an essential component of education plans. So, I think there are new areas there that could be usefully explored in terms of intersectoral approach to the neglected tropical diseases. No disease should be neglected, especially not these diseases which have such profound consequences for health and development.
Reports from working group: Action points for integrated control

Working groups

The partners recognize that sustainable control of neglected tropical diseases will progress when partners willingly cooperate in the planning and delivery of interventions, which should occur at the global, country and district levels. The key partners in this activity are the governments of countries where the infections and diseases are endemic. Leadership from governments is the foundation for control.

Each group was challenged to propose action points in response to a theme related to the control of neglected tropical diseases. In this context, control depends largely on public health interventions based on integrated mass chemotherapy. The following three themes were addressed by the working groups:

**Group I** (Chair, Dr Rakesh Srivastava; Rapporteur, Dr Bjorn Thylefors)
Integration of activities and interventions for the control of neglected tropical diseases

**Group II** (Chair, Dr Uche Amazigo; Rapporteur, Dr John Ehrenberg)
Coordination of control activities at the country level

**Group III** (Chair, Dr Rakesh Srivastava; Rapporteur, Dr Riadh Ben-Ismail)
Intensified delivery of interventions to sustain optimal coverage

The groups were asked to consider four questions as they dealt with the three themes: (i) What are the priority actions that could advance integrated control? (ii) What are the relevant roles for government ministries, nongovernmental organizations and the community? (iii) What roles should WHO adopt at all levels (international, regional, country) to assist partners? (iv) What difficulties have partners experienced when working with WHO?
The 24 action points proposed by the working groups are detailed below in no order of priority. Occasionally, action points were proposed by more than one group.

- Governments should express strong political commitment to control and develop a national plan for control of neglected tropical diseases. The plan should include targets to be reached by rapid and cost-effective interventions.
- Each country should select its best model for ensuring good interaction between programmes to achieve cost effectiveness in all aspects of control interventions.
- Ministers should allocate a dedicated budget and staff for control activities and should seek resources and technical help from partners to accelerate control.
- Rapid and accurate mapping techniques should be used in the planning and implementation of control activities. WHO should consider taking the lead in developing this tool for use in control programmes.
- The arrival and distribution of donated drugs need to be carefully integrated into the interventions for which they are intended and scheduled for when they are needed.
- Integration depends on control programmes for neglected tropical diseases becoming part of the primary health-care system.
- WHO should assume its normative technical function and remain a facilitator for technical coordination, as evidenced by the publication of recent guidelines for preventive chemotherapy. Guidelines for monitoring and evaluation of preventive chemotherapy are now required.
- WHO should consider the appointment of technical advisory staff at the country or inter-country level to facilitate the implementation and scaling up of control programmes.
- The strong public health case for closer collaboration between the programmes for neglected tropical diseases and measures for the control of zoonoses should lead to synergistic, integrated action.
- The training of community distributors and health personnel at the district level is a key issue for control and for scaling up of control activities.
- Opportunities to integrate the control of neglected tropical diseases with other programmes, such as distribution of bednets to control malaria or actions for HIV/AIDS, should be sought and implemented.
- Ministries of health should allocate funds to create a task force with responsibility for mapping the distribution and documenting the epidemiology of neglected tropical diseases prevailing in the country. This work is essential for establishing priorities for resource allocation.
- Member States should endorse control of neglected tropical diseases at the World Health Assembly in 2008 to stimulate governmental commitment to control interventions.
- There is a need to compile a global register or inventory of all the activities of known partners and the many other agencies that contribute to the control of neglected tropical diseases in all the countries where the diseases are endemic. This register would aid governments in the tasks of coordinating activities and recruiting new partners for control in their countries.
- The register would also assist WHO in organizing advocacy meetings to increase the number of donors and to propose country-specific interventions to promote and extend control.
- Regional forums attended by ministries with common agendas, such as overlaps between health, education, agriculture and water supply, could contribute to effective control programmes with better integration.
- Ministries of health should accept responsibility for obtaining low-cost technology to gain information about control needs, targets and results and arrange to share the information with all partners.
- Build the capacity of countries to gather and analyse data and communicate results. The process would be helped if donors were to contribute to costs since this aspect of capacity building is such an important component of control programmes.
Governments and partners in new control programmes should take advantage of experience gained in long-standing programmes.

WHO should take responsibility for developing guidelines and training materials for integrated control for all levels of the process with a view to strengthening human resources.

Health education is a key component of social mobilization and in sensitizing communities to the programme. It fosters good compliance, local ownership and local empowerment.

Cross-border collaboration is to be encouraged to share experiences and coordinate essential cross-border control activities.

Regional meetings dealing with programmes for neglected tropical diseases should be held annually and the information shared should be widely disseminated.

Achieving high coverage of the intervention is most important for the control of neglected tropical diseases.

Conclusion

Closing remarks by Dr David Heymann, Assistant Director-General, Communicable Diseases, World Health Organization

This Global Partners’ Meeting is a turning point, or a series of turning points, at several different levels as we seek to control neglected tropical diseases.

Infectious diseases fall into three different categories: (i) those that cause high mortality such as HIV/AIDS, tuberculosis and malaria, (ii) those that are emerging or re-emerging, such as severe acute respiratory syndrome and avian flu; and (iii) those that cause chronic disability and insidious ill-health, such the neglected tropical diseases. WHO will take note of and act upon the 14 recommendations made by the Strategic and Technical Advisory Group concerning neglected tropical diseases.

Diseases in categories (i) and (ii) have always attracted greater funds and a larger share of available resources. Now, thanks to the establishment of effective partnerships, funds, support and expertise are coming together to reduce the burden of chronic suffering that affects so many of the world’s poor people. Neglected tropical diseases are now beginning to receive as much attention in WHO as do the other two categories of communicable disease.

Crucial to the effort to reduce suffering and foster national development is the commitment of the governments of the countries where neglected tropical diseases are endemic.

Crucial to the effort is the generosity of the pharmaceutical industry; at this meeting we have received the welcome news of donations of mebendazole and of praziquantel, drugs that will be provided free of charge to those in need. We have heard of partnership successes in dealing with leprosy, lymphatic filariasis, onchocerciasis, schistosomiasis and trachoma. What is particularly encouraging, and crucial to further sustainable success, is to realize that the organizations behind these achievements are combining their skills and resources to form greater partnerships that will have a still greater impact in improving the health and well-being of poor people.

Let me remind you of how a partnership can work by telling you about the Polio Partnership. This partnership has many international partners with four spearheading partners (Rotary International, the United States Centers for Disease Control (CDC) and Prevention, UNICEF and WHO). Each has a specific task, each does that task and each sticks to that task. Rotary has gained access to high levels of government. Many Rotarians are from the business community, they are experts at advocacy and in mobilizing funds. CDC provides technical support and consultants to plan and help implement eradication campaigns. UNICEF provides social mobilization, while WHO provides coordination and guidance. Some US$ 500 million is still needed for polio eradication; amazingly, some US$ 5 billion has already been raised and spent in making enormous inroads into the scourge of polio. Partnerships can set and reach objectives, and poor people can enjoy a healthier, polio-free future. Think how much progress could be made in tackling neglected tropical diseases if US$ 500 million became available every year.

His Excellency the President of Burkina Faso suggested that perhaps the time has come to establish a global fund for neglected tropical
diseases as we have for HIV/AIDS, tuberculosis and malaria. The Minister of Health for Morocco proposed that we have a World Day for neglected tropical diseases. Mrs Hashimoto spoke about the importance of ensuring that neglected tropical diseases become a prominent item on the agenda of the G8. Samuel Eto'o urged us all, based on his childhood in Cameroon, to give the highest possible priority to dealing with neglected tropical diseases. The representative from the World Bank, with the needs of poor children in mind, discussed how their health care could be linked to educational provision. And the Vice-President, in his keynote address, challenged us to support the efforts of his government to improve the health of its citizens. All governments must face and overcome the challenge of neglected tropical diseases.

There is no doubt that WHO recognizes the importance of meetings such as these, where partnerships are strengthened, where experience is shared and where inspiration is gained. We already need a partner to come forward and start to arrange the next meeting. Through our Director-General’s leadership, the importance and profile of neglected tropical diseases are now firmly placed in the global public health agenda. There can be no turning back. On her behalf, on behalf of our Deputy Director-General and of the WHO Communicable Diseases Cluster, I thank you most sincerely for your attendance and contributions. More importantly, I thank you on behalf of the millions of poor people whom you are striving to help.
Annex

Participants representing the global partners

GUESTS OF HONOUR

His Royal Highness Prince Abdulaziz Ahmad Abdulaziz Al Saud, Chairman, Eastern Mediterranean Region, International Agency for the Prevention of Blindness, Saudi Arabia
His Excellency Mr Blaise Compaoré, President, Burkina Faso
Mr Samuel Eto’o, International footballer, Cameroon
Mrs Kumiko Hashimoto, Philanthropist, Japan
His Excellency Dr Ali Mohamed Shein, Vice-President, United Republic of Tanzania

MEMBER STATES

Austria

Dr Helmut Friza, Minister Plenipotentiary (Public Health), Permanent Mission of Austria to the United Nations Office in Geneva and the Specialized Agencies in Switzerland
Ms Christina Kokkinakis, Deputy Permanent Representative, Permanent Mission of Austria to the United Nations Office in Geneva and the Specialized Agencies in Switzerland

Brazil

Dr Jose Ricardo Pio Marins, Coordinator, Communicable Diseases, Secretary of Health Surveillance, Ministry of Health
Dr Fabiano Pimenta, Secretary of Health Surveillance, Ministry of Health

Burkina Faso

Mr Paul Balma, Adviser to the Office of the Presidency of Burkina Faso
Mr Moussa Nebie, Chargé d’Affaires a.i., Permanent Mission of Burkina Faso to the United Nations Office in Geneva and other International Organizations in Switzerland
Mr Lamine Sow, Adviser to the Office of the Presidency of Burkina Faso
Mr Alain Bédouma Yoda, Minister of Health
First Global Partners’ meeting on NTDs

Cameroon
Dr Francis Ngantcha, Chargé d’Affaires a.i., Permanent Mission Cameroon to the United Nations Office in Geneva and other International Organizations in Switzerland

China
Professor Tang Linhua, Director, National Institute of Parasitic Diseases, Chinese Center for Disease Control and Prevention

Democratic Republic of the Congo
Mr Sebastien Mutomb Mujing, Minister Counsellor, Permanent Mission of the Democratic Republic of the Congo to the United Nations Office in Geneva and other International Organizations in Switzerland

Egypt
Professor Wahid Doas, Director-General of Hepatology and Tropical Institute, Ministry of Health and Population
Dr Esmat Sheba, Secretary General for the Higher Committee for Medical Specialties, Ministry of Health and Population
Dr Zeinab Youssef, Undersecretary for Endemic Disease, Ministry of Health and Population

France
Dr Gilles Champetier de Ribes, Ministry of Foreign Affairs
Ambassador Mr Jean Maurice Ripert, Permanent Mission of France to the United Nations Office in Geneva and other International Organizations in Switzerland
Mrs Jeanne Tor-de Tarlé, First Secretary, Permanent Mission of France to the United Nations Office in Geneva and other International Organizations in Switzerland

Ghana
Dr John Gyapong, Programme Manager and Director, Health Research Unit, Public Health Division, Ministry of Health

Germany
Dr Assia Brandrup-Lukanow, International Public Health Adviser to the Health Metrics Network, Denmark
Dr Jan Eckendorf, Permanent Mission of Germany to the United Nations Office in Geneva and other International Organizations in Switzerland

Honduras
Ms Gracibel Bu Figueroa, Minister Counsellor, Permanent Mission of the Republic of Honduras to the United Nations Office in Geneva and other International Organizations in Switzerland

India
Dr Rakesh Srivastava, Director General of Health Services, Ministry of Health and Family Welfare

Italy
Ms Lucia Fiori, Minister Counsellor, Permanent Mission of Italy to the United Nations in Geneva and other International Organizations in Switzerland
Japan
Ambassador Mr Ichiro Fujisaki, Permanent Mission of Japan to the United Nations in Geneva and other International Organizations in Switzerland
Dr Naoko Nihei, Department of Medical Entomology, National Institute of Infectious Diseases
Professor Tsutomu Takeuchi, Department of Parasitology and Tropical Medicine, Keio University, School of Medicine
Dr Seiko Tateno, Director of Expert Service Division, Bureau of International Cooperation, International Medical Center of Japan, Ministry of Health, Labour and Welfare

Morocco
Dr Mohamed Cheikh Biadillah, Minister, Ministry of Health
Dr Noureddine Chaouki, Director, Epidemiology and Disease Control, Ministry of Health
Mr Nour-Eddine Halilou, Permanent Mission of Morocco to the United Nations in Geneva and other International Organizations in Switzerland
Mr Mohammed Loulichki, Permanent Mission of Morocco to the United Nations in Geneva and other International Organizations in Switzerland

Mozambique
Dr Quintas Fernandes, National Health Institute, Ministry of Health
Dr Rassul Nnalá, Biologist, National Health Institute, Ministry of Health
Dr Mouzinho Saide, National Director of Health, Ministry of Health

Myanmar
Dr Kyaw Nyunt Sein, Deputy Director-General, Disease Control, Department of Health, Ministry of Health

Spain
Mr Guillermo López Mac-Lellan, Adviser, Permanent Mission of Spain to the United Nations Office in Geneva and other International Organizations in Switzerland
Mrs Elena Madrazo-Hegewisch, Deputy Director, Multilateral and Horizontal Cooperation, Spanish Agency for International Cooperation
Mrs Isabel Noguer, Deputy Director General, Department of International Research Programs and Institutional Relations, Programmes and Institutional Relations, Carlos III Health Institute
Mr Carlos Segovia, Assistant to Deputy Director General, Department of International Research Programs and Institutional Relations, Carlos III Health Institute

Sri Lanka
Dr Ajith Mendis, Director General of Health Services, Ministry of Healthcare and Nutrition

Sudan
His Excellency Dr Abdulmagid Mohamed Nour, State Minister of Health, Federal Ministry of Health

Uganda
Honorable Dr Stephen Mallinga, Minister of Health, Ministry of Health
Her Excellency Cissy Tuliwaku, Deputy Ambassador, Permanent Mission of the Republic of Uganda to the United Nations Office in Geneva and other International Organizations in Switzerland
Dr Sam Zaramba, Director General of Health Services, Ministry of Health
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**United Kingdom**
Dr Stewart Tyson, Head of Profession for Health, Department for International Development

**United Republic of Tanzania**
Honorable Dr Aisha Omari Kigoda, Deputy Minister, Ministry of Health and Social Welfare
Dr Mohammed Khalifan, Programme Manager, Integrated Helminth Control Programme, Zanzibar
His Excellency Matern Y.C. Lumbanga, Ambassador, Permanent Mission of the United Republic of Tanzania to the United Nations Office in Geneva and other International Organizations in Switzerland
Honorable Sultan Muhammed Mugheiry, Minister, Ministry of Health and Social Welfare, Zanzibar
Mr Geophrey Mizengo Pinda, Protocol Officer, Ministry of Foreign Affairs & International Cooperation
Honorable Professor David Mwakyusa, Minister of Health and Social Welfare, Ministry of Health and Social Welfare
Mr A. Shaween, Deputy Chief of Protocol

**United States of America**
Dr Mark L. Eberhard, Director, Division of Parasitic Diseases, Centers for Disease Control and Prevention
Dr Irene Koek, Chief, Office of Health, Infectious Diseases Division, United States Agency for International Development

**PARTNERS AND AGENCIES**

**Asian Development Bank, Philippines**
Dr Vincent de Wit, Principal Health Specialist

**Bayer Environmental Science S.A., France**
Dr Gerhard Hesse, Head, Global Portfolio Management Vector Control

**Bayer HealthCare AG, Germany**
Dr Kemal Malik, Head, Global Development and compliance
Dr Michael Schuetter, Head Health Policy, BHC-COM Health Policy

**Bill & Melinda Gates Foundation, United States of America**
Dr Kathryn Aultman, Senior Program Officer, Infectious Diseases Global Health Program
Dr David Brandling-Bennett, Senior Program Officer, Infectious Diseases Global Health Program
Dr Regina Rabinovich, Director, Infectious Diseases Global Health Program

**Carter Center, United States of America**
Dr Donald R. Hopkins, Associate Executive Director
Centre Hospitalier Ibn Rochd, Morocco
Professor Kamal El Filali Marhoum, Medecin-Enseignant, Service des Maladies Infectieuses, Faculté de Medecine de Casablanca

Carlos III Health Institute, Spain
Mr D. Agustin Benito Llanes, Head, National centre of Tropical Medicine

Central University of Venezuela, Venezuela
Dr Oscar Noya Gonzalez, Director, Institute of Tropical Medicine, Faculty of Medicine

Christian Blind Mission, Germany
Dr Rudolf Czikl, Regional Director Central Africa Regional Office (Kenya)
Dr Adrian Hopkins, Central Africa Regional Office (Kenya)

Commission of the African Union, Pan African Tsetse and Trypanosomiasis Eradication Campaign, Ethiopia
Dr John Kabayo, Coordinator, African Union Headquarters

DBL - Centre for Health Research and Development, Denmark
Dr Jens Aagard-Hansen, Senior Researcher, Medical Anthropology, University of Copenhagen

Drugs for Neglected Diseases Initiative, Switzerland
Mr Jean-François Alesandrini, Advocacy & Fundraising Director
Ms Nicoletta Dentico, Policy & Advocacy Manager
Dr Bernard Pecoul, Executive Director

ECLAT, United Kingdom
Dr Chris Schofield, Coordinator, London School of Hygiene and Tropical Medicine

Æterna Zentaris, Germany
Professor Dr Juergen Engel, Executive Vice President, R&D and Chief Operating Officer/Chairman and Managing Director, Zentaris GmbH

European Centre for Disease Prevention and Control, Sweden
Mrs Zsuzsanna Jakab, Director

European Commission, Directorate for Health, Belgium
Dr Ole Olesen, Director-General Research, Poverty-related Diseases Unit, European Commission Directorate for Health
Dr Dario Zanon, Research Director-General, Infectious Diseases

Fast Track Initiative, United States of America
Dr Desmond Bermingham, Head

FIOCRUZ, Brazil
Professor Dr Paulo M. Buss, President
Professor Dr Rodrigo Correa Oliveira, Head of the Laboratory, Laboratory of Cellular and Molecular Immunology
Foundation for Innovative New Diagnostics, Switzerland
Dr Giorgio Roscigno, CEO

Food and Agriculture Organization of the United Nations, Italy
Dr Katinka De Balogh, Animal Health Officer, Livestock Information, Sector Analysis and Policy Branch, Animal Production and Health Division
Dr Joseph Domenech, Chief Veterinary Officer, Animal Health Service

GAIN, Switzerland
Dr Barbara Macdonald, Senior Manager for the Performance Measurement and Monitoring Program

Geneva Global, United States of America
Mr Mark Forshaw, Sector Manager, Health

Global Alliance to Eliminate Lymphatic Filariasis, United Kingdom
Mrs Joan Fahy, Executive Group Coordinator, Executive Group/Programme Coordinator, Lymphatic Filariasis Support Centre
Professor David Molyneux, Executive Secretary, Executive Group/Professor of Tropical Health Sciences, Liverpool School of Tropical Medicine

Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland
Dr Christophe Benn, Geneva Secretariat
Dr Mark Grabowski, Geneva Secretariat
Dr Michel Kazatchkine, Executive Director
Dr Stefano Lazzari, Senior Health Adviser, Geneva Secretariat

Global Health Futures Network
Dr Roy Widdus, Consultant

GlaxoSmithKline, United Kingdom
Mr Ian Boulton, Director, Communication Strategy (United Kingdom)
Dr David Stout, President, Pharmaceuticals Operations (United States of America)
Mr Andy Wright, Director, LF Elimination Programme, Global Community and Partnerships (United Kingdom)

Helen Keller International, United States of America
Dr Chad MacArthur, Director of Training and Community Education, Director of Trachoma
Ms Kathy Spahn, President

Institut de Recherche pour le Développement, France
Dr Jean-François Girard, Chairman of the IRD Board of Trustees
Dr Bernadette Murgue, Adviser on Health to IRD’s Society and Health Department

Institut Pasteur, France
Professor Alice Dautry, President
Professor Marcel Hommel, Medical Director
Institute of Tropical Medicine “Pedro Kouri”, Cuba
Professor Dr Gustavo Kouri, Director-General, Cuban Academy of Sciences,
Director, Institute of Tropical Medicine

International Atomic Energy Agency, Austria
Dr Udo Feldman, Joint FAO/IAEA Division of Nuclear Techniques in Agriculture

International Federation of Pharmaceutical Manufacturers & Associations, Switzerland
Dr Stefanie Meredith, Director of Public Health Partnerships
Dr Lika Panchenko, Coordinator, Public Health Partnerships

International Federation of Red Cross and Red Crescent Societies, Switzerland
Dr Bruce Eshaya-Chauvin, Head, Health and Care

International Trachoma Initiative, United States of America
Mr Ibrahim Jabr, Vice-President, Programmes
Dr Jacob Kumaresan, President

Ivo de Carneri Foundation, Italy
Dr Alessandra Carozzi de Carneri, President
Dr Marco Albonico, Secretary General
Dr Deborah Cocorullo, Project Manager

Izumi Foundation, United States of America
Ms Catherine Bryant, Program Officer

James Cook University, Australia
Dr Wayne Melrose, School of Public Health & Tropical Medicine

Japan International Cooperation Agency, Ghana
Dr Jun Nakagawa, Regional Advisor, JICA-PAHO, Chagas Disease Vector-Control

Johnson & Johnson, United States of America
Dr Sharon D’Agostino, Vice-President, Worldwide Corporate Contributions and Community Relations
Dr Anu Gupta, Director, Corporate Communications
Dr William Lin, Manager, Corporate Contributions
Mr William Weldon, Chairman & CEO

Kids for World Health, France
Ms Eloïse Jannin, Lycée de la Versoie
Mr Simon Lapierre, Lycée de la Versoie

Korea University, Republic of Korea
Professor Han-Jong Rim, Professor Emeritus
La Caixa Foundation, Spain
Mr Ricardo Fornesa, President

Lancet, United Kingdom
Dr Astrid James, Editor

MLight for the World, Austria
Mr Rupert Roniger, Managing Director

Liverpool School of Tropical Medicine, United Kingdom
Professor Janet Hemingway, Director
Professor Harold Townson, Selwyn-Lloyd Professor of Medical Entomology

Mebendazole Donation Initiative, United States of America
Dr Nana Twum-Danso, Director

Mectizan® Donation Program, United States of America
Dr Björn Thylefors, Director

Médecins Sans Frontières, Switzerland
Dr Christophe Fournier, President of the International Council

MedPharm, United States of America
Mr Andrew Koval, President and Chief Executive Officer

Merck & Co., Inc., United States of America
Mr Ken Gustavsen, Manager, Global Product Donations
Dr Adel Mahmoud, Former President, Merck Vaccine Division, Senior Molecular Biologist
Professor Woodrow Wilson School of Public and International Affairs

Merck KGaA, Germany
Dr Juergen Knackmuss, Spokesman, Public Relations
Dr Wilhelm Ott, Local Specialities, CM Care and Operations, Merck Serono Division
Mr Elmar Schnee, Member, Executive Board, Merck KGaA, Head, Merck Serono Division

Merck Serono International S.A., Switzerland
Ms Stéphanie Lauber, Department of Communications

Micronutrient Initiative, Canada
Dr Venkatesh Mannar, President

National Institute of Public Health
Dr Mario Henry-Rodriguez, Director-General, Mexico

MSD Interpharma, France
Mr Michel Iguer, Vice-President, Middle East and Africa region
National Academy of Medicine, France  
Professor Pierre Ambroise-Thomas, President

National Institute of Medical Research, United Republic of Tanzania  
Dr Mwele N. Malecela-Lazaro, Director of Research

National Institute of Public Health, Mexico  
Dr Mario Henity-Rodriguez, Director-General

Noguchi Memorial Institute for Medical Research, Ghana  
Dr Toshiki AwazawaProfessor Alexander Nyarko, Director

Nongovernmental Development Organization Coordination Group for Onchocerciasis Control, United Kingdom  
Dr Adrian Hopkins, Former Chairman

Novartis Foundation for Sustainable Development, Switzerland  
Professor Klaus M. Leisinger, President and Chief Executive Officer

Organisation pour la Prévention de la Cécité, France  
Dr André-Dominique Negrel, Executive Director and Vice-President

Oxfam International, United Kingdom  
Mrs Celine Charveriat, Director, Oxfam International Advocacy (Switzerland)

Pan American Health and Education Foundation, United States of America  
Dr Jess Gersky, Executive Director

Paris School of Economics, France  
Dr Elizabeth Beasley, J-PAL Europe

Pfizer Inc, United States of America  
Ms Paula Luff, Director, International Philanthropy  
Mr Robert L. Mallett, Senior Vice-President, Stakeholder Alliances, Philanthropy & Corporate Citizenship/ President of the Pfizer Foundation

RTI International, United States of America  
Dr Eugene Brantley, International HealthDr Mary Linehan, Deputy Director, NTD Control Program

RISEAL, France  
Dr Bertrand Sellin

Royal Commonwealth Society for the Blind (Sight Savers International), United Kingdom  
Dr Caroline Harper, Chief Executive
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Sabin Vaccine Institute, United States of America
Professor Peter Hotez, President/Walter G. Ross Professor and Chair of Microbiology, Immunology, & Tropical Medicine, George Washington University

Samuel Eto’o for Health, Spain
Mr Samuel Eto’o, President
Mr José M. Mesalles Mata, Vice-President
Mr Alejandro Echevarría, Treasury

Sanofi-Aventis, France
Mr Alain Aumonier, Associate Vice President, Relations with International Institutions
Dr Jean-François Dehecq, President and Chief Executive Officer
Mr Michel Labie, Senior Vice-President Communications and Institutional & Professional Relations
Mr Robert Sebbag, Senior Vice-President, Access to Drugs

Save the Children, United States of America
Ms Regina Keith, Senior Health Policy Officer (United Kingdom)
Ms Natalie Roschnik (United States of America)

Schistosomiasis Control Initiative, United Kingdom
Professor Alan Fenwick, Director/Professor of Tropical Parasitology, Imperial College London

SecureAid Ltd, United Kingdom
Mr Peter Brown, Chairman

Shin Poong Pharm. Co., Ltd., Republic of Korea
Mr Won-June Chang, Managing Director

Sightsavers International, United Kingdom
Mr Simon Bush, Regional Director, West Africa

Spanish Agency for International Cooperation, Spain
Mrs Elena Madrazo-Hegewisch, Deputy Director, Multilateral and Horizontal Cooperation

St. George’s University, Grenada
Professor Calum N.L. MacPherson, Director of Research

Swiss Tropical Institute, Switzerland
Dr Marcel Tanner, Director

Task Force for Child Survival and Development, United States of America
Dr Eric Ottesen, Director

UNICEF
Dr Robert Davis, Keny
University of Glasgow, United Kingdom
Professor Paul Hagan, Dean of the Faculty of Biomedical and Life Sciences

Vision2020
Dr Abdulaziz I. Al Rajhi, President of the Middle East African Council of Ophthalmology/
Co-Chair of the International Agency for the Prevention of Blindness Eastern Mediterranean
Region

Volkswagen Foundation, Germany
Dr Detlef Hanne, Programme Manager, Africa-Initiative, Earth and Environmental Sciences

Wellcome Trust, United Kingdom
Dr Ted Bianco, Director of Technology Transfer
Professor Dr Jimmy Whitworth, Head of International Activities

World Bank, United States of America
Dr Ousmane Bangoura, Onchocerciasis (river blindness) Coordination Unit
Dr Donald Bundy, Lead Specialist, School Health and Nutrition

World Food Programme, Italy
Dr Francisco Espejo, Chief, School Feeding Service, Policy Strategy and Programme
Support Division

World Organization for Animal Health (OIE), France
Dr Tomoko Ishibashi, Deputy Head of Department, Scientific and technical Department
Dr Bernard Vallat, Director General

World Vision International, Switzerland
Mr Thomas Getman, Executive Director, International Liaison Office

WHO SECRETARIAT
Headquarters, Geneva
Dr Anarfi Asamoah-Baah, Deputy Director-General
Dr Robert Beaglehole, Director, Chronic Diseases and Health Promotion
Dr Margaret Chan, Director-General
Dr Steffen Groth, Director, Essential Health Technologies
Dr David Heymann, Assistant Director-General, Communicable Diseases
Dr Bill Kean, Executive Director, Office of the Director-General
Dr Robert Ridley, Director, Special Programme for Research and Training in Tropical Diseases
Mr Alex Ross, Director, Partnership and United Nations Reform
Dr Michael Ryan, Director, Epidemic and Pandemic Alert and Response
Dr Lorenzo Savioli, Director, Control of Neglected Tropical Diseases
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Regional Office for Africa
Dr Barryson Andriamahefazafy, Regional Adviser, Other tropical Diseases
Dr Uche Veronica Amazigo, Director, African Programme for Onchocerciasis Control

Regional Office for the Americas
Mr Steven Ault, Regional Adviser, Communicable Diseases

Regional Office for the Eastern Mediterranean
Dr Riadh Ben-Ismail, Regional Adviser, Tropical Diseases and Zoonoses

Regional Office for South-East Asia
Dr Vasanthapuram Kumaraswami, Communicable Diseases

Regional Office for the Western Pacific
Dr John Ehrenberg, Regional Adviser, Malaria, and other Vector-borne and Parasitic Diseases
Dr Antonio Montresor, Public Health Specialist, Vector-borne and other Parasitic Diseases

Strategic and Technical Advisory Group on Neglected Tropical Diseases (STAG)
Professor David Crompton, Temporary Adviser, University of Glasgow
"The neglected tropical diseases provide another example of our solidarity. These diseases do not travel internationally, threaten the health or economies of wealthy countries, or make headline news. Yet they cause immense suffering and disability for millions of people and anchor them in poverty. The world is now paying attention to these diseases and making progress in unprecedented ways, with ambitious goals, excellent interventions, and growing evidence of multiple benefits for health. This attention to long-neglected diseases is a positive sign that health is a responsibility shared by the international community."

Margaret Chan, Director-General, World Health Organization

Department of Control of Neglected Tropical Diseases (NTD)
World Health Organization
20, Avenue Appia
1211 Geneva 27, Switzerland
E-mail: ntddocs@who.int
http://www.who.int/neglected_diseases/en/