Neglected tropical diseases in the post-2015 health agenda

The recent Editorial (April 12, p 1269) on neglected tropical diseases (NTDs) was published at a crucial time for the UN’s post-2015 development agenda. We commend The Lancet for emphasising the importance of including NTDs in the sustainable development goals, as discussions continue after the report by the High-Level Panel of Eminent Persons on the post-2015 development agenda. The WHO Strategic and Technical Advisory Group (STAG) on Neglected Tropical Diseases met in Geneva on April 8–9, 2014, after World Health Day focused on vector-borne diseases this year. These events have highlighted significance for the global public health of vector-borne diseases and NTDs. The WHO NTD STAG recognised the importance of the Paris meeting discussed in the Editorial and appreciated the continued commitments of partners to NTD elimination and control. These meetings recalled the 2013 World Health Assembly Resolution (WHA 66.12), which highlighted strategies necessary to accomplish the WHO Road Map targets that all Member States endorsed. The STAG meeting urged the global health community to ensure 100% use of donated drugs (all of which are on the WHO model list of essential medicines), in line with the WHO NTD Roadmap. This step would represent country commitment to NTD elimination, ensure equity in distribution of health resources, and reflect the global commitment to the poverty alleviation agenda and universal health coverage.

NTDs affect the most vulnerable people in low-income and middle-income countries. Dengue fever, an emerging vector borne disease, poses an increased threat to all continents, and burgeoning urban populations are the most at risk. It is clear that any Sustainable Development Goals must consider the effect of NTDs on human health and socioeconomic development. Access to NTD interventions is an integral part of universal health coverage. Their positive effect in gains for healthy life and reduction in catastrophic health expenditure represent a route out of poverty for households. Access to NTD interventions also reduces financial burden on health systems in almost all countries. Control and elimination of NTDs are sensitive indicators of both poverty alleviation and universal health coverage, and are representative of how developing countries care for the health of the poorest sections of their populations. 1

I declare no competing interests.

Peter Holmes, on behalf of the WHO Strategic and Advisory Group on Neglected Tropical Diseases

University of Glasgow, Glasgow G12 8QO, UK


Investing in obstetric surgery and anaesthesia to close the gap in maternal mortality

Substantial reductions in maternal deaths were achieved under the auspices of the Millennium Development Goals; to continue in the post-2015 era, investment and accelerated scale-up of maternal health intervention packages delivered within health systems is required, as highlighted by Karin Stenberg and colleagues (April 12, p 1333). 3

Obstructed labour and post-partum haemorrhage remain leading causes of maternal mortality worldwide. Although incidence can be reduced through the presence of skilled birth assistants and active management of the third stage of labour, closing the gap in maternal deaths within a generation requires simultaneous investment in emergency obstetric surgical and anaesthetic care, including for caesarean section and blood product services. Although excluded from the Investment Framework proposed by Stenberg and colleagues, these are evidence-based interventions to reduce maternal mortality in high-income and in low-income and middle-income countries (LMICs). They have been included in previous publications on essential interventions for maternal health, but are typically excluded from investment frameworks and economic modelling. 5

Such neglect shows a broader aversion in the global health community to fund the development of hospital-level services in LMICs, including those for essential surgery and anaesthesia. Cost and complexity are often cited as major barriers to the scale-up of hospital-level care, yet closer examination shows caesarean section for obstructed labour prevents maternal mortality and obstetric fistula, has favourable cost-benefit ratios, is highly cost effective by WHO standards, and can be delivered safely at district-level facilities, including by non-physician providers. 3,6

Failure to include hospital-based obstetric surgical and anaesthetic services, and to support infrastructure such as blood banks within maternal health investment frameworks for LMICs, underestimates the true investment required to reduce maternal mortality to acceptable global standards. Furthermore, such an approach weakens investment in secondary care services generally, threatening progress towards a diverse range of health and development goals in the medium to long term.

We declare no competing interests.

*Anna J Dare, Rowan Gillies, Sarah L M Greenberg, Iain H Wilson

King’s Centre for Global Health, King’s College London and King’s Health Partners, London SE5 9RJ, UK (AD); Program in Global Surgery and Social Change, Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA (RG, SLMG); and Royal Devon and Exeter NHS Foundation Trust, Exeter, UK (IHW)
Cervical cancer mortality in India

Randomised trials in India have compared mortality from cervical cancer in 224,929 women offered cervical screening with 138,624 women offered no screening whatsoever.1,2 At least 254 women in unscreened control groups died from cervical cancer.3 Were study participants given adequate information to provide informed consent?4 If not, journals reporting data from these studies are not compliant with international recommendations about human research protections.

In 2007, in The Lancet, Sankaranarayanan and colleagues reported that cervical screening, as compared with no screening, reduced cervical cancer mortality in Tamil Nadu.5 Inexplicably, death rate measurements in unscreened women have continued, even after mortality benefit from screening had (predictably) been confirmed. So far, it is uncertain whether any screening has been offered to any women in unscreened control groups in Tamil Nadu.

We declare no competing interests.

Eric J Suba, Stephen S Raab
eric.suba@gmail.com

Authors’ reply

Repeated rounds of Pap smear screening, as done in high-income countries, are not feasible in developing countries, because of the level of resources required. Such models of screening in Latin American countries had little effect on cervical cancer incidence and mortality.1 Our study in Dindigul district, Tamil Nadu, India—a cluster-randomised trial and implementation group during July, 2007–December, 2011, after which we provided screening to the women in the remaining areas of Dindigul district outside the context of the research project. As a consequence, the cervical cancer incidence rates in the district have substantially declined in recent years.4

After the significant reduction in cervical cancer incidence and mortality in our study, the Tamil Nadu Government has been scaling up VIA screening, through existing health services, to cover the entire state in a phased manner since 2007, thereby rapidly showing effectiveness in a local randomised trial and implementation in everyday health care.5 Our study provided the scientific basis for visual screening to become the standard of care for cervical cancer prevention in the state of Tamil Nadu since 2007 and no doubt accelerated access to these benefits among women for whom they were previously out of reach.