



DevelopmentAid Dialogues

Episode 18 Season 3



Season 3. Episode 18: Cheap cures, fragile systems: Inside the ongoing fight to end neglected tropical diseases. A conversation with Dr. Wendy Harrison.

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Hisham Allam: Hello, everyone. Welcome to DevelopmentAid Dialogues. I'm your host, Hisham Allam. Today, we explore global strategies to eliminate neglected tropical diseases or NTDs, the real progress, tough challenges, and how Unlimit Health speeds up impact for vulnerable communities. My guest today is Dr. Wendy Harrison, CEO of Unlimit Health since twenty-nineteen. She joined in two thousand and nine as part of its NTD control effort at Imperial College London. She's co-president elect of the Royal Society of Tropical Medicine and Hygiene. Also has been working to bridge human and animal health from early projects in Uganda and Rwanda.

Dr. Harrison, welcome to DevelopmentAid Dialogues.

Wendy Harrison: Thank you very much. It's a real pleasure to be here.

Hisham Allam: To start us off, let's hear about your journey in this field. What initially drew you to specialize in neglected tropical disease, and how has the field evolved over your career?

Wendy Harrison: Thank you, Hisham. So perhaps just a very quick reminder about neglected tropical diseases. So, neglected tropical diseases are a group of about 21 diseases that actually have nothing in common from a biological perspective. What they do have in common is that they all affect populations that have real poor access to healthcare and other basic services.

They're often thought of as diseases of diseases of really marginalized neglected populations. And over half of those diseases also have other species in their life cycle. So, whether that's mosquitoes, snails, insects, but also dogs, pigs, water buffalo, and other animals. This is the point at which my personal interest starts. I grew up as a child on a dairy farm, and I trained as a veterinary surgeon, so I've always been interested in that relationship between animal health and human health. I was doing a postdoc in at the University of Georgia, and I got the opportunity to volunteer for veterinary public health charity who donated animals so livestock, to low and middle-income countries.

And I was very lucky to be able to spend some time with them in their Uganda and Rwanda program. And it was there that I really saw the huge impact of that linkage of animal health of livestock health and human health and that kind of environmental approach as well.



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And it really struck me, the potential opportunity of making a significant impact, and particularly for people living under those really difficult and very marginalized conditions. So actually, shortly after that I went back to the London School of Hygiene and Tropical Medicine, and I got my master's in human public health in low- and middle-income countries.

And then I went on to work actually at my present organization. So, in terms of how the field has evolved in the almost 20 years that I've been working in this area I think really at the beginning the sort of idea of putting these 21 now diseases together recognizing that they affected the same population of people, I think was incredibly effective in raising the profile of these debilitating diseases.

And this, I think, was in a way part of the reason that the sector was able to mobilize the support that it did from the US and the UK government and also a number of other European governments, but also some of the philanthropic organizations, so obviously the Bill and Melinda Gates Foundation heavily invested.

And interestingly my organization was one of the very first recipients of the Gates grant. And so, I think it's very interesting how that kind of idea of bringing those diseases together had been so powerful. But now I think as we move along the journey of progress and making some really important strides in tackling these neglected tropical diseases, that it's becoming more important to really understand more of the epidemiology and the context in which these different diseases occur.

So, I think now we're moving away slightly to thinking more about the kind of context and the individual disease requirements than perhaps looking at these diseases in a bigger group.

Hisham Allam: That's fascinating, especially seeing those shifts firsthand. Turning to Unlimit Health itself, which its mission is to share evidence and expertise to end preventable parasitic infections, what does this look like in practical terms for NTD affected communities?

Wendy Harrison: Unlimit Health is an international NGO. And we partner with ministries of health in endemic countries to tackle four of the NTDs. So, we primarily focus on schistosomiasis and three of the soil transmitted helminths, so that's roundworm, whipworm and hookworm.

Schistosomiasis, as many people might know as bilharzia, is actually transmitted through freshwater snails, during contact with water contaminated with feces or urine from infected people. But has a massive global burden. So, there's over 250 million people affected by schistosomiasis, and just as a kind of context, there are about 40 to 45 million living with HIV AIDS.

So, it gives the scale of global burden, and this is a disease that actually many people have never heard of. And soil transmitted helminths affect over 1.5 billion people, so that's almost one person in every six people globally, impacted by these diseases.

And as we said, like all NTDs, they predominantly impact those really marginalized communities where they've got very little access to health and other basic services. And they really have the highest impact on children. And here they cause physical impact, so they cause anemia, malnutrition, and stunting.



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They lead to chronic organ damage, liver fibrosis, bladder cancer, and they also increase the risk in women of contracting HIV about fourfold. But beyond that individual suffering, which as you can imagine, is devastating; they also really perpetuate this cycle of poverty because they reduce the ability of children to go to school, to get any level of educational attainment. They limit productivity.

They really constrain the economic development of these affected regions. So, they really do perpetuate this sort of vicious cycle of poverty. So how at Unlimited Health do we aim to end these diseases that obviously have such a profound impact?

Exactly as you say, we use evidence-based interventions. So, this is one of our key tenets that the interventions that we always use are very well scientifically validated.

Hisham Allam: Can you explain this more, just to enable us to understand it?

Wendy Harrison: Yes. Essentially, as you mentioned we started, as a research group within the School of Public Health at Imperial College.

And what we were tasked by Gates Foundation to do was to run a proof-of-concept study to show that you can deliver national scale schistosomiasis treatment at a high coverage. So, you need to really facilitate the impact. You need very high coverage of children and adults at risk with a treatment which is called schistosomiasis.

And you also need to be able to monitor that coverage very effectively and ensure that you have the right target population covered. So, we use really well-validated techniques to make sure that we are delivering that treatment of praziquantel in the most affected way.

The other way that we work is very much in partnership because we know from the life cycles of these diseases that we need a number of sectors, not only just the health sector and a number of actors, the communities themselves, the governments, the funders, to work together in really strong long-term partnerships to be able to deliver this effect.

And we very much like the African proverb that you probably know, which is "If you want to go quickly, you go alone, but if you want to travel far, you must travel together." And we very much believe that long-term partnerships are absolutely essential, and we recognize that each of those partners does have crucial information that is important to develop affected interventions.

And thirdly, and I guess possibly most importantly, is that we work directly with Ministry of Health colleagues. So, we really try and ensure that our programs are absolutely aligned with national strategy. So, the country plans for disease control and elimination. And really make sure that the decision-making sits within the Ministry of Health, recognizing that these are Ministry of Health programs.

And really also taking into account that we know that many of our colleagues from endemic countries have critical knowledge, expertise and understanding that, is really important to deliver effective programs.



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Hisham Allam: Those examples really show the ground level difference. Now, Dr. Harrison, I would like to ask you which recent Unlimited Health milestones or program are you most excited about right now?

Wendy Harrison: Oh well, that's a great question, and actually, if I may, I would actually like to highlight two areas. So one is, is more pragmatic and one perhaps a little bit more strategic.

The first one is actually around our ability to expand the populations that we are able to treat. As an organization, we started in 2002 and in our long history we have been able to deliver really large numbers of treatments.

In our last financial period in '24, '25, we delivered over 30 million treatments, and in our history, we have actually supported one billion treatments in about 15 endemic countries. So, we really do have a track record of delivering on scale. But we deliver treatments mainly to school-aged children and at-risk adults, and obviously this is a really key pillar of the control program.

And how we do that is through mass drug administration. So, we identify areas of high burden of disease, and then we're able to deliver treatments to entire communities that we know are at high risk. So rather than having to individually diagnose and treat each person, we're able to do it at a community implementation unit level.

And this is possible because the drugs have a very strong safety profile. So, we're able to deliver these very effectively. But we know that children much younger than school-aged children are often at high risk of exposure. And I don't know whether you've ever been to Lake Malawi and probably any other lake in that area.

And you often see very small children, often babies, sitting at the water's edge, often maybe in a washing-up bowl, while their mother or older siblings are doing washing in the slightly deeper water. And they often look like actually they're enjoying themselves, but it's this kind of repeated exposure to this contaminated water that can actually lead to infections.

And previously, no treatment was possible for those very young children. And that obviously then allowed the parasites to then continue to reproduce and produce really serious symptoms as the children get older. Unlimited Health as part of a bigger public-private partnership, including Merck KGaA, which is one of the manufacturers of praziquantel, was able to develop and pilot a new formulation of the drug that could be used in children as young as three months old.

It's called AR praziquantel, a pediatric praziquantel, and we've been able over the last 18 months to support the pilot distribution to children in Uganda, Côte d'Ivoire, and we're currently mobilizing resources for another distribution in Zanzibar. So, this is really exciting because it has the potential obviously to identify and treat an issue in very young children but also prevents the longer-term morbidity that is associated with young children having these worm infections for a long period.

And we're really hoping that this is gonna have a really important impact on the physical health and development of these children.

Hisham Allam: This is exciting to hear.



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Wendy Harrison: So, then if I may just also highlight a second area which is actually more about how we are delivering these mass drug administration campaigns.

So traditionally, we've delivered them working with our Ministry of Health colleagues as programs specifically focused on treating of schistosomiasis. So, we run them as standalone campaigns. And part of the reason that this has occurred is because the donors that support these kinds of programs, and particularly bilateral donors have been particularly focused on the ability to identify the number of people reached by the treatment program and also to quantify the impact, and obviously this is hugely important.

And in the short term, the most effective way of doing that is to run these very vertical disease campaigns. But it does mean that often the NTD programs become quite siloed, so they're really outside of the health system budgeting and governance structures because they're run as a vertical program, and also they're funded externally.

So, this has meant that the resources allocated to these programs, although it's very efficiently delivered in the short term against these very specific disease targets, they've really missed the opportunity to use those disease-specific resources to strengthen the capacity of the existing system.

So, for instance, for disease control planning, for monitoring, reporting and also there's a potential of benefiting from synergies of working with other campaigns and essentially an economies of scale of working together.

Hisham Allam: Sorry for interruption, but on the funding side, which is always a key concern for development work, we are witnessing funding pressure in global health. How do you build donor confidence for sustained NTD investment?

Wendy Harrison: That is again an absolutely crucial question. And I think we first of all have to acknowledge, don't we, that there is significant funding cuts, particularly as we saw with USAID has had very profound effects. And actually, I think a WHO report recently showed that there's over 140 million people who haven't received the preventative treatment for NTDs that they were due to receive.

I think the funding cuts have been very significant. But I think that's such an interesting question around how we do build this confidence and I think probably just taking a moment to look back at what were the original reasons that some of these donors like USAID, the UK Government, actually invested in NTDs of back in the 2000s 2010s.

And this was really, I think largely based on the cost effectiveness of these interventions. And obviously that was influenced by the Copenhagen consensus that was happening around that time. But NTD control really is considered to be one of the top global investments, a sort of best buy in global health.

And again, as I've said, it's because they're safe and effective medicines, and we can deliver those w- to entire populations. And obviously there's some kind of contextual differences, of broadly you can deliver a treatment for less than 50 cents.

They really are seen as very cost effective, interventions and that continues. So, I think the data around that cost effectiveness is also increasing, which I think gives quite a lot of confidence to donors. And we've some really



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interesting engagement with movement, called the Effective Altruism Movement. So essentially, they're just a kind of social movement that advocates for philanthropic giving, but using evidence, to maximize that global good. So really prioritizing, again, those cost-effective high impact investments.

But I think we would argue that cost effectiveness is actually only part of the picture. It's obviously very powerful. And I do think really does give donors and other actors real confidence. But it's quite a short-term measure, and what it doesn't capture really is the long-run benefits or the wider impact of actually investing in stronger systems that can deliver for the long term and also can deliver across different health areas.

So that's why I'm so excited about this kind of strategic shift because I think integrating mass drug administration for NTDs into existing national health campaigns and we've recently supported in Uganda, integration of schistosomiasis treatment into child health days that are run by the Ugandan Ministry of Health.

Because on the one hand, they can also demonstrate that you're increasing efficiency essentially by benefiting those synergies and some of those economies of scale. But also by working directly with the Ministry of Health to identify those points where the different disease campaign can be integrated with systems that already deliver treatments, that already track data, that already manage logistics, that we can strengthen those core functions so that we have, high level monitoring, we have high level reporting and we have really robust supply chains. So, that over the long term we're actually building greater confidence in those government-led Ministry of Health systems, which then increase their ability to manage programs effectively, and that ensures that any investment made by external funders when that does come, the countries are really positioned to allocate that funding to their own priorities which actually have a much greater long-term impact on a much broader number of health problems.

Hisham Allam: These practical steps could make a real shift, but I'd like to broaden this out to the wider impacts. How do NTD programs contribute to broader sustainable development goals, like poverty reduction or gender equity?

Wendy Harrison: That again, is a really interesting question, and I think we often think about health interventions in quite a narrow way. So perhaps if I can use an example just to illustrate that, and I've just recently been to Madagascar.

So, if we could imagine a, an eight-year-old Madagascan girl living in a rural setting who becomes infected with schistosomiasis because she'd been down to collect water from an infected water source. So, the parasite will penetrate her skin, travel through her blood vessels and remain around her urogenital organs, and that'll start to produce eggs that will set up this chronic inflammatory response.

She also will have picked up some parasites, some soil-transmitted helminths that will remain in her gut. So, we can imagine that by treating her for those parasites will make a significant impact on her physical health. So that's obviously SDG3. But also, by removing the parasites, particularly in her gut, it will mean that she'll be able to absorb more of the nutrients from her food, which sadly often is of poor quality. And so that will also contribute to SD 2, which is around zero hunger and better nutrition. Some really interesting studies in Kenya have shown that treatments against parasites of school-aged children actually increase school attendance by up to 25%. So actually treatment of parasites is an effective educational intervention.



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So that really supports attainment of SDG4 around education. Now, if Clara doesn't get treated and grows older, she'll be at an increased risk of contracting HIV. And as I said before that there's a fourfold increase in her likelihood of getting HIV because of the inflammation around her urinary tract.

So, this will cause discomfort, infertility, and can be mistaken for sexually transmitted diseases. So that means that she's probably subjected to stigma. Also, a female relative is most likely needing to look after her. So, the treatment of these parasitic diseases also has a real impact on gender equality, which of course is SDG 5.

Also reducing contamination of water sources, which is a really important part of disease control. And that will also have impact on disease on SDG Goal 6 about water and sanitation. And just finally, there's again, another really interesting long-term study that was conducted in Kenya by Michael Kremer, who actually went on to win a Nobel Prize showed that actually if you give anti-parasitic drugs in childhood you boost their household income as adults by about 13%.

So actually, these treatments also potentially have an impact on SDG 1 obviously around poverty. So, I think that's 6 of the 17 SDGs that have a kind of really direct link with parasitic disease control.

Hisham Allam: Dr. Harrison, let's shift to some of the biggest forces at play. How is climate change reshaping NTD transmission patterns in your focus regions?

Wendy Harrison: It is a massively important area. And actually interesting, we just presented to our board an example of the impact of the severe flooding in Malawi that happened in 2019 and then again with the tropical cyclone Freddy in 2023. Sorry, 2023.

And we were able to show that actually from our baseline surveys of the prevalence and intensity of schistosomiasis in 2019, there was a really significant increase in the prevalence because of the increase of floodwater and streams that obviously allowed the snail vectors to inhabit and continue the transmission cycle.

So those extreme weather events really do increase often the burden of diseases in already affected communities. But I also think climate change, as we see, really also changes the geographical range of some of these diseases.

And we obviously see vectors such as mosquitoes, where diseases like dengue fever, lymphatic filariasis, and obviously malaria where the temperature changes allowed those mosquitoes to survive. And I know again, there was a WHO report. There was a significant resurgence of chikungunya, which is also another NTD that has an insect as a vector in Europe where it hadn't been seen before.

Also, I think that because we are dealing with working with communities that have very little access to basic medical services, that often these extreme weather events really disrupt people's means of livelihood, so they're less able to afford healthcare. And also, it does weaken the health systems that would deliver healthcare and implement the control systems.



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I think in areas where NTDs are prevalent the climate does really exacerbate even further the, those, the impact of these diseases. And I think another large area is around the sort of migration of climate affected populations, and I think that's really reshaping transmission patterns of many of these diseases.

And people might have been aware that a few years ago there was actually an outbreak of schistosomiasis in Corsica. And this had been tracked back to people who were thought to be leaving Senegal in West Africa, and they brought the infection over, and the parasite was able to establish a life cycle actually in the River Cava, which is in the southern part of Corsica because they had the *Bulinus* snails there, they were native to the region. And that obviously set up a transmission cycle, and that went on to infect, I think, over 120 tourists.

Hisham Allam: This is a stark reminder of how interconnected this all is. I'd like to discuss with you what role data or digital tools, or community health workers play in tracking and accelerating the progress?

Wendy Harrison: Absolutely. All three of those play an absolutely vital role in accelerating progress. So, we know that obviously data for decision-making is absolutely crucial in all health programs. But actually, I would argue that data is most crucial for schistosomiasis of actually all the NTDs.

And that is because schistosomiasis is a very focal disease, and so often it will occur in a single community in an area. So it's really important that we're able to identify exactly where are the highest burdens of disease and ensure that we target our resources to those areas that actually require intervention.

And it's also really important that we're able to gather the accurate data around what the impact is because then we're able to adapt any of our treatment strategies. We're able to identify what are any barriers and really look for what other interventions might be required. So the data is absolutely essential, and we obviously support our Ministry of Health colleagues to collect that data and make sure that data is transparent and as visible. And actually, there's a special project of the World Health Organization on NTDs that's known as ESPEN, and they've done a great job of collecting all the global data on NTDs and providing a data repository and making this accessible. So obviously that's really important in terms of planning and implementing these disease control programs.

Now digital tools obviously are becoming increasingly important and as I said, it's really vital for us to know where the highest burdens diseases are. But actually, to generate that really accurate data at that very granular scale takes quite a lot of resources to collect that data.

So, what we're doing at Unlimit Health with a number of partners and particularly working with the London School of Hygiene & Tropical Medicine, is to look at tools that use the existing data that we have and using model-based geo-statistics to really be able to identify these high-risk areas but using data that's already available or using data that may not be very up to date. But this allows you to predict and identify these high-risk areas that allows you to target interventions and really ensure that the resources that are available are going to the right places and reduces the amount of resource that you need to collect that accurate data.

And we're also using digital tools for data collection and particularly around coverage surveys. And obviously because there's a very high coverage of smart phones in many of the areas that we work in Sub-Saharan Africa, we're able to develop a number of apps that are able to collect and collate the in real time.



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And lastly, you mentioned community health workers who are absolutely central to all of the NTD programs. And often health workers are volunteering their time to support NTD programs. And they're often crucial in the actual delivery of the treatments but also providing information to communities in a real context and appropriate way, really supporting communities to understand the benefits and impacts of treatment campaigns, but also how to manage their day-to-day risks to really reduce disease transmission and really understand at the community level where barriers to treatment might lie and really build that kind of trust with community. So again, absolutely essential for any progress in this area.

Hisham Allam: These are smart ways to close those gaps. Dr. Harrison, what is one persistent misconception about parasitic disease that you would like to correct?

Wendy Harrison: Again, a really great question. I think one of those misconceptions is that ending parasitic diseases can be achieved by the health sector alone, or in fact, it's the responsibility of the health sector.

Of course, we know that kind of treatment and identifying high-risk areas using diagnostics is absolutely essential. But if we genuinely want to stop people getting infected in the first place, we have to think far beyond a sort of biomedical paradigm. If we think about schistosomiasis, obviously, if we treat someone every year, but the water sources they rely on remain contaminated, then obviously, although we've reduced significantly the burden of their disease, they are going to be reinfected. So, without - environmental interventions, safe water sanitation infrastructure, and better ways of managing human and animal waste, we really aren't gonna make the kind of progress that we need and what the communities that are affected deserve.

And then obviously there's thinking about the animal health sector. So obviously as a veterinarian, that's an area which I'm particularly focused on. And we know that many communities that are affected by NTDs share their environment really closely with livestock. And some NTDs I mentioned earlier require or have animals as part of their life cycle.

And an example that actually we're starting to work on is a disease called *Taenia solium*, which is a pork tapeworm, and people become infected by eating contaminated undercooked pork. And obviously, there's a very specific collaboration there that's needed with pig farmers and the veterinary public health sector to prevent that cycle of infection.

But also, I think beyond that, there's also a real need to think about how we utilize resources across both the human and animal health sectors. And interesting sometimes agricultural or animal health workers are the kind of most medically qualified professionals who regularly visit some of the really remote communities.

And there's a really great example, which is actually quite old now, but from Chad, where agricultural extensions workers who were vaccinating animals in pastoral communities, they were asked to vaccinate women and children at the same time as they vaccinated livestock. Now, really interestingly, they reached more women and children than the medical teams did, who were obviously primarily only focused on human health.

So, it really shows that power of being able to look much more holistically at health in the broadest possible sense and really utilize the resources that we do have available to really maximize the amount of health, whether that be animal or, and human health that we can receive.



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And there's also really important sectors like nutrition and, as I mentioned, it's really important as a to support food programs to ensure that the parasites aren't actually undermining the impact of nutrition programs and also education 'cause we know that children infected with parasites go to school less often and have less educational attainment.

So, I guess that the kind of idea that because it's a disease, because it's a medical condition, that it's purely the responsibility of the medical profession I think is the myth that I would most like to debunk. Because in reality, these diseases are much more of a reflection of how people live, how people work, how people farm, how people access water and services.

And really ending them requires a real collaboration across a whole kind of ecosystem of partners working together.

Hisham Allam: Dr. Harrison, in brief, what structural barriers still block certain regions from scaling profit into the interventions?

Wendy Harrison: Great. Thank you. That's again a really interesting question. And as I've said, we do have these very proven cost-effective tools for most NTDs. But I think the biggest structural barrier is actually the systems that we rely on to deliver them are incredibly fragmented.

And for many years as I've mentioned previously, NTDs programs were set up as these very vertical disease specific programs. Which obviously made sense as we've talked about when we're focused on really rapid scale-up. But these programs often sit outside of health budgeting, planning and delivery systems.

And so, this sort of architecture, the aid architecture where funding comes into these very vertical programs, I think is really one of those structural barriers. And it's not actually just about the kind of flow of money through these kinds of vertical systems; it's also about the time horizons and the incentives.

'Cause donors often will fund in quite a short cycle. They prioritize those immediate sort of coverage numbers, and that pushes countries to repeat the same thing, trying to make it a bit cheaper, but really doesn't give them the opportunity, as we were mentioning earlier, to invest in the underlying system that would eventually make these campaigns unnecessary.

And there's really very little incentive for building of that local sort of system capacity or for strengthening those surveillance systems that we will need going forward. And I think there's also, the kind of multiple donors that fund these vertical programs obviously also promote fragmentation within the ministries themselves.

So, there isn't really a strong mechanism that brings together, all those different sectors that I talked about, education, WASH, agriculture, the environment, around this shared objective. And that's really unfortunate for NTDs because they are diseases of poverty. They are diseases that are endemic.

They don't typically cause these kinds of dramatic outbreaks, so they tend to fall really to the bottom of the political priority list. And they're sometimes almost taken for granted that this is part of the background level of suffering that people have to endure.



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So, I think the barriers aren't technical. I think they're structural. And I think that the tools do exist, but without these kind of integrating, coordinating mechanisms and long-term financing and political prioritization, actually, these tools don't really reach their full potential.

Hisham Allam: Tough hurdles, but naming them is the first step. To wrap up your thoughts on the longer view, looking beyond 2030, what gives you optimism about the future of tropical disease elimination?

Wendy Harrison: Oh, thank you. And what a nice question to end on. So, I am optimistic that particularly over the last few years we've really got an appreciation of a need for this systems-based approach, and I think we've really moved from the sort of rhetoric and as I mentioned, the WHO roadmap really supports this idea of system-based approaches, which was published back in 2021.

But I think now we've really moved into a phase where we're understanding how you do this, how you take resources for neglected tropical diseases and how you implement them in a way that both achieves the disease outcomes that you want but also strengthens the system that you're using.

I think I'm optimistic about that. I'm also optimistic that we are really getting a better understanding of how to work in authentic partnerships across different sectors. We're really starting to understand each other's language and really build those partnerships where there's mutual accountability and we really are all working towards a shared goal.

And I guess lastly, what I'm always really optimistic about and that is just the level of resilience and innovation in the communities that we work with. So, these are the people that have the least access to resources and spending time in those communities and witnessing the way that they create solutions is really an absolute privilege and always gives me a huge sense of optimism.

I guess that I am confident and I am optimistic that it is our strapline at Unlimit Health, that together we can end parasitic disease

Hisham Allam: I offer now to end on that note, thank you, Dr. Harrison. Thank you for joining DevelopmentAid Dialogues and sharing these vital insights on NTD elimination strategies from progress to persistent challenges.

Listeners, if this conversation has sparked ideas for your development work or policy discussions, please subscribe whenever you get your podcast, share this episode with your network, and visit developmentaid.org for related resources and funding opportunities in global health. I'm Hisham Allam signing off. Goodbye.