Leaving no one behind in sleeping sickness elimination: Opportunities & gaps within Uganda's integrated refugee policy

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INZI Investigating Networks of Zoonosis Innovation

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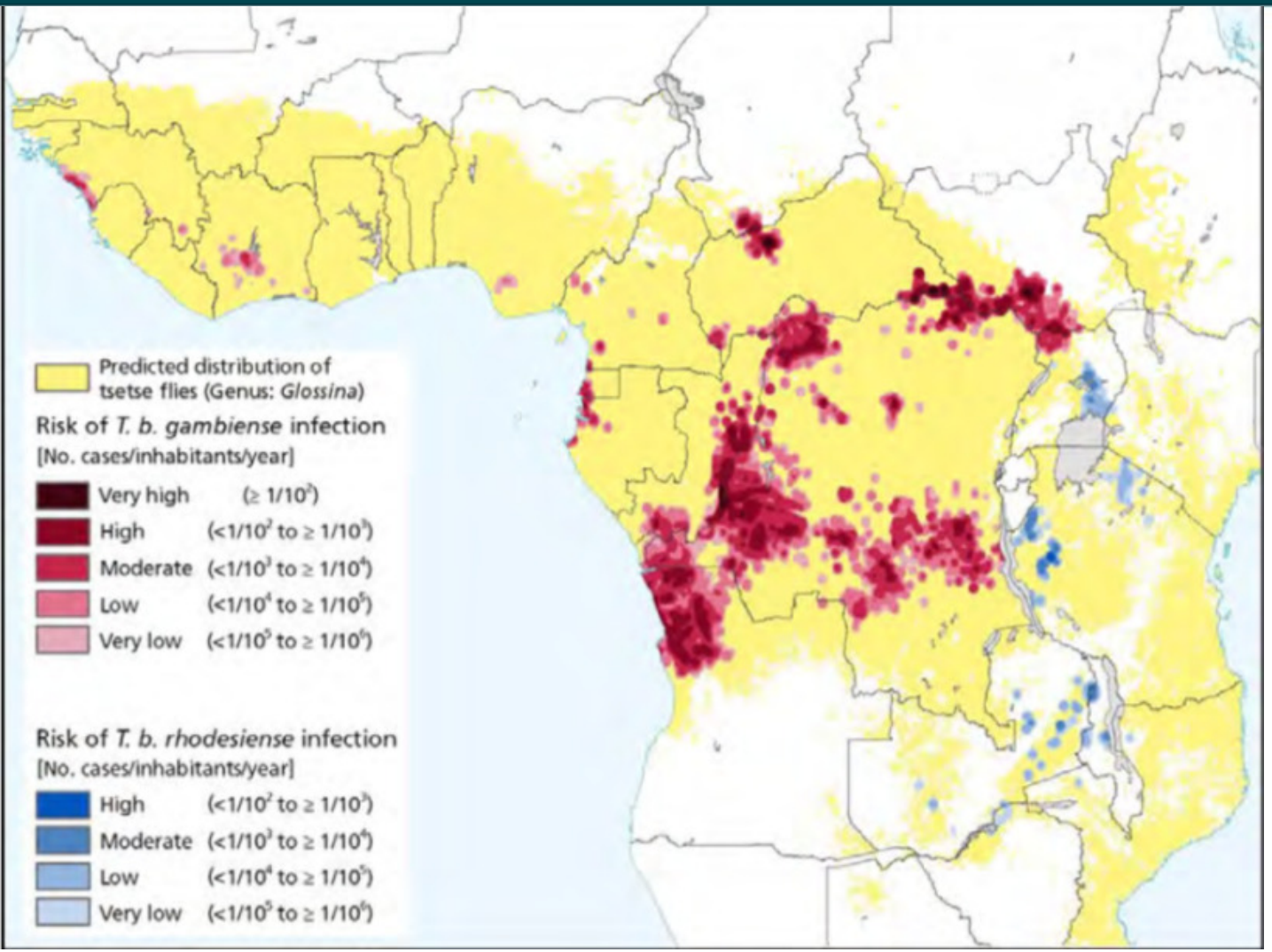
Sleeping sickness & forced migration



- Affects mind & body, fatal without treatment
- Outbreaks associated with conflict & forced migrations
- Humanitarian agencies historically important actors
  - MSF treated 30% of cases at epidemic peak
  - MSF 4th largest R&D donor
- All endemic countries host forcibly displaced populations

Sleeping sickness elimination: a changing landscape

Nascent elimination targets & guidelines

- 1st sleeping sickness target in 2012

New technologies & strategies

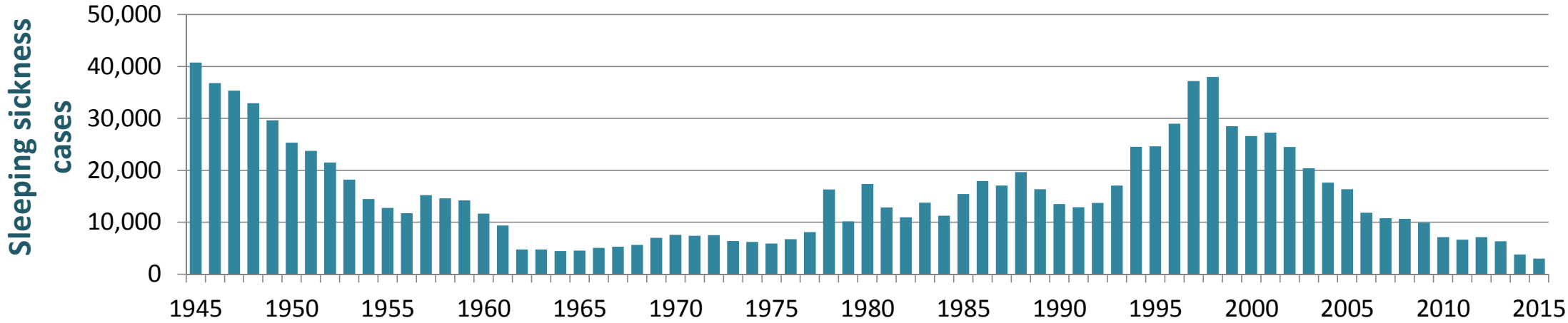
- 1st sleeping sickness RDT, oral drugs, tsetse control innovations
- Half of cases detected through 'research'

New actors

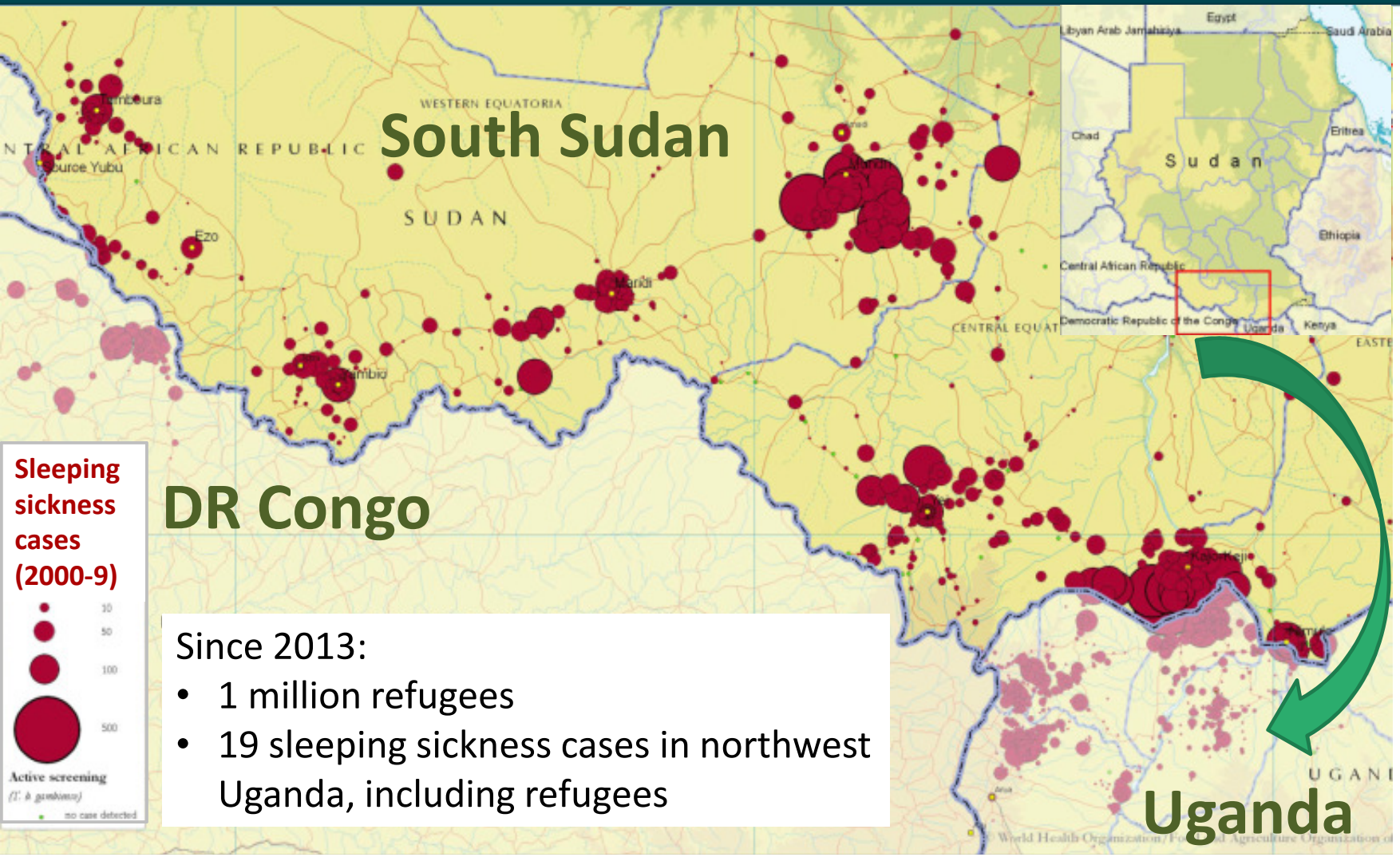
- Belgian govt, Gates Fdn, Product Development Partnerships (DNDi & FIND, both part-funded by DFID)

Fewer cases, more displacement

- Natl program staff responsible for all: control / research, refugees / host pop



Forced migration to Uganda



Promising policy context:

- Refugees served in govt health facilities

- Sleeping sickness RDTs available in govt health facilities

…but challenges…

Programmatic challenges during refugee influx

1. Unbalanced international financial support to government services
   - UNHCR prioritises primary healthcare
   - Little $$ to expand vertical programmes

2. Sleeping sickness coordination staff reluctant to engage humanitarian coordination structures

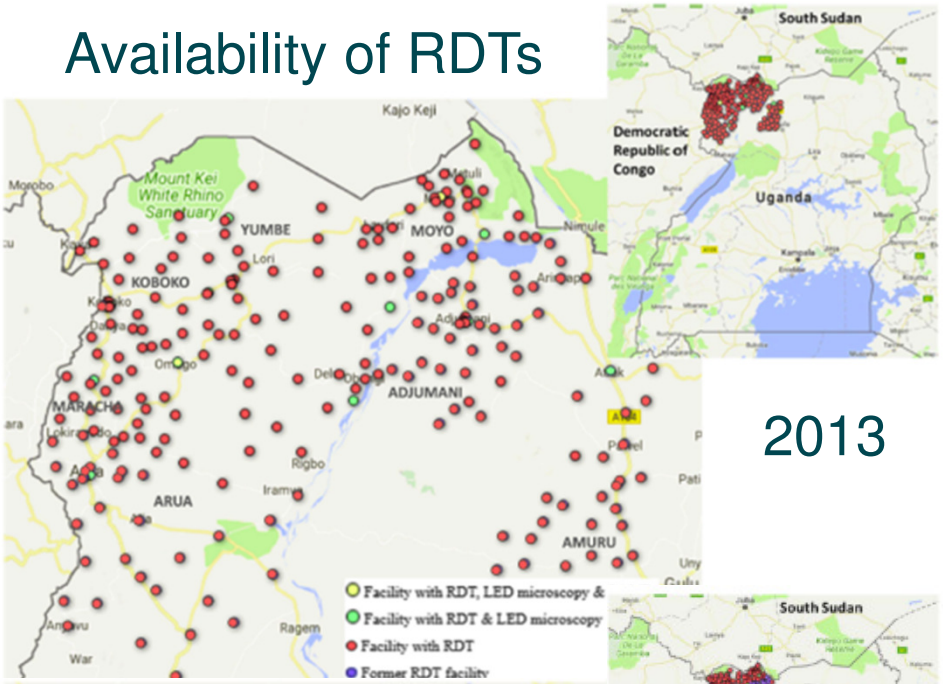
3. Rapid expansion of health teams → sleeping sickness RDT knowledge & norms lost

4. Difficulties screening for a rare disease through different languages & cultures

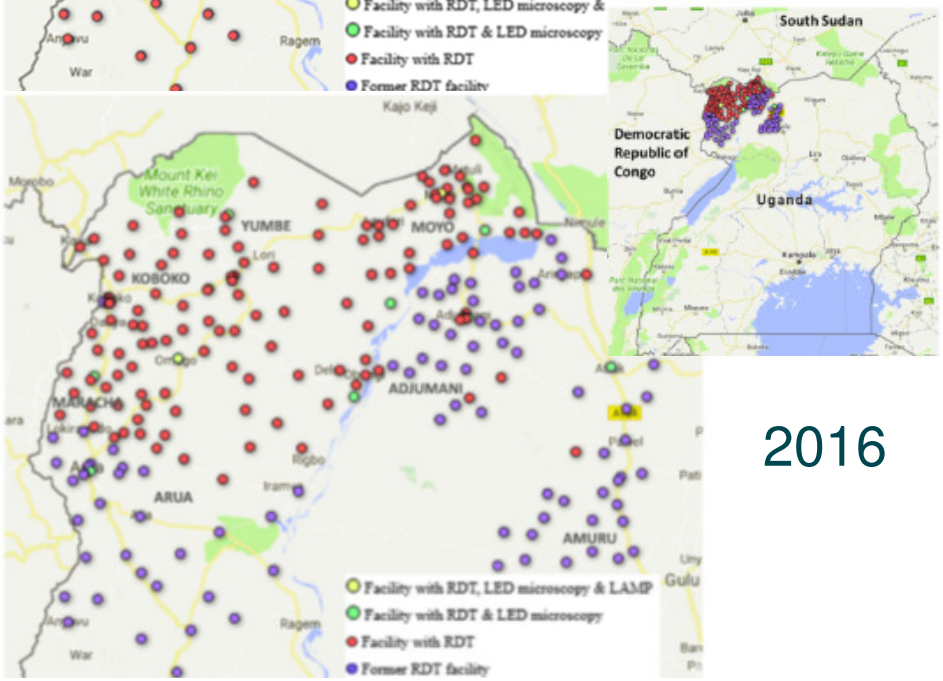
In refugee settlements:

RDTs hardly used → Little surveillance data produced → No cases to prompt suspicion

Availability of RDTs



2013



2016

5. No international guidance on acceptable rate of RDT use for elimination

6. Perceived pressure to demonstrate value for money
   - Program cost to add/keep an RDT facility: $300/a

7. Momentum of original plan:
   - Withdraw surveillance resources (as quickly as possible) in areas judged to have low disease risk

Programmatic outcomes

- Surveillance gaps in some areas densely populated by refugees
- Opinion of refugees: access to sleeping sickness tests better before displacement

More information:

Palmer *et al. Conflict and Health* (2017) 11:22
DOI 10.1186/s13031-017-0125-x

Conflict and Health

RESEARCH Open Access

Including refugees in disease elimination: challenges observed from a sleeping sickness programme in Uganda

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PLOS ONE

RESEARCH ARTICLE

Enhanced passive screening and diagnosis for *gambiense* human African trypanosomiasis in north-western Uganda – Moving towards elimination

Charles Wamboga[1☯], Enock Matovu[2☯], Paul Richard Bessell[3], Albert Picado[4], Sylvain Biéler[4], Joseph Mathu Ndung'u[4]*

Gaps in the evidence base

- How best to serve forcibly-displaced populations in an elimination context?
- What level of case detection (reach & quality) is needed to verify elimination?
- How best to monitor elimination equity between host & displaced populations?

Gaps in policy work

- How to conceptualise the responsibilities of host governments & partners towards refugees during elimination?
- How to support/incentivise host governments & partners to anticipate needs of displaced populations during elimination?

Implications for DFID

→ Clear governance gap in supporting elimination of HAT (and potentially other NTDs) in fragile states and forcibly displaced populations