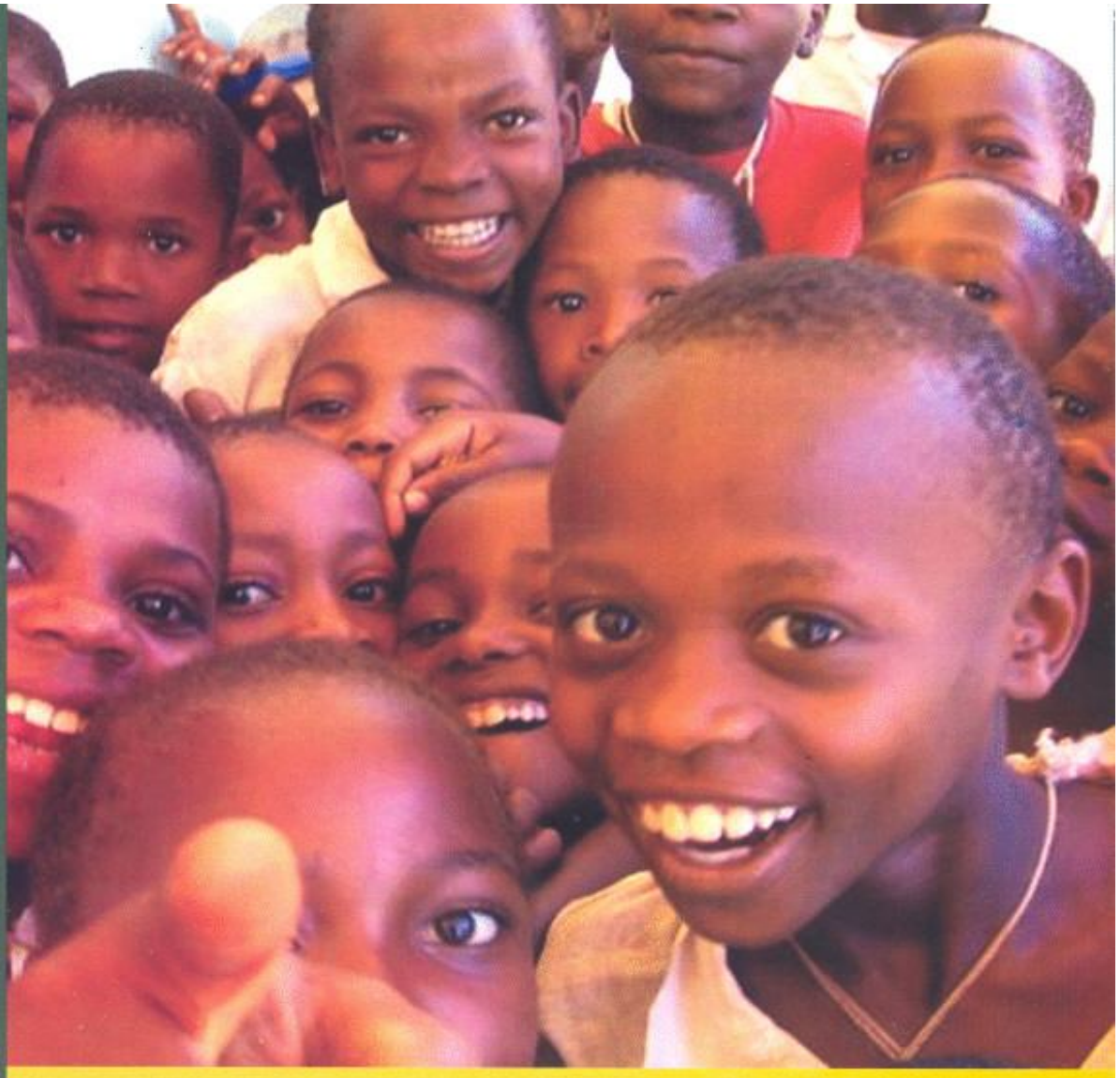
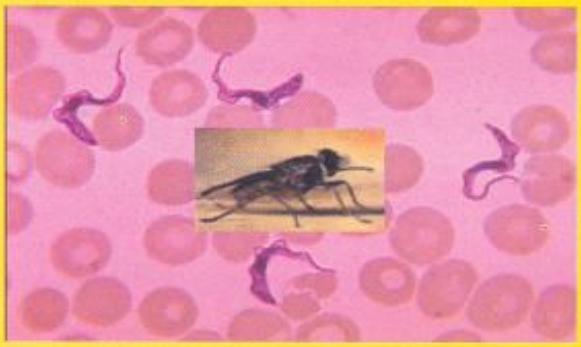
African Trypanosomiasis





Strategic Plan for Advocacy
Phase I: 2008-2011

Towards a continent free of trypanosomiasis

FIND
foundation for innovative new diagnostics

FOREWARD

Following the decision by African Heads of State and Government to embark on a Pan African Tsetse and Trypanosomiasis Eradication Campaign (PATTEC), an office was established at the African Union Commission to coordinate the implementation of the decision. The PATTEC Coordination Office serves to drum up action; mobilise commitment; promote, initiate, enhance and sustain intervention activities against trypanosomiasis; and build effective partnerships in Africa's efforts to eliminate the scourge of trypanosomiasis. The office is mandated to remind affected countries about their individual and collective obligations to the implementation of PATTEC and is required to monitor and report the progress to the African Union Summit every year.

One particular difficulty, which the PATTEC initiative continues to face is the fact that trypanosomiasis, is still regarded by many as merely one among a litany of other problems, which plague the continent of Africa. Against the long list of the continent's critical emergencies, including HIV/AIDS, malaria, tuberculosis, conflicts, safe drinking water and a host of other health, social and development priorities, trypanosomiasis does not always attract sufficient attention to warrant the necessary action. There is therefore a need to highlight the significance and negative impact of trypanosomiasis on the lives and livelihood of people and remind affected countries about their obligations to the implementation of the decision to eradicate the disease, particularly given the availability and feasibility of methods to eliminate the disease once and for all.

In the past few years, several countries have started projects aimed at eradicating trypanosomiasis, some have developed national plans for tsetse and trypanosomiasis eradication, but many others have not yet initiated action. Two countries, Botswana and Namibia, which were recently rendered tsetse and trypanosomiasis-free, have provided an example on the feasibility of success in attaining the objectives of PATTEC. To achieve the final objective of eradicating trypanosomiasis from Africa, it is crucial to generate the commitment necessary to inspire the required intervention action in all the affected countries.

In this connection, the PATTEC Coordination Office recognises the need to develop a strategic advocacy plan aimed at mobilising the action necessary to execute the final push against trypanosomiasis. The strategic plan that has been developed is expected to enhance the on-going advocacy activities being undertaken by the PATTEC Coordination Office and provide a guide in addressing the information and activity gaps, which exist at various levels, including political leaders, the general population, affected communities, decision-makers and development partners. The African Union Commission highly appreciates the support and collaboration of the Foundation for Innovative New Diagnostics (FIND) and other partners towards the achievement of this goal.

John P. Kabayo
PATTEC Coordinator

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ACRONYMS

AT	African Trypanosomiasis (both human and animal species)
AAT	African Animal Trypanosomiasis
AU	African Union
CBOs	Community Based Organisations
CDF	Community Development Fund
CSF	Cerebrospinal fluid
DALYs	Disability Adjusted Life Years
DFMO	Diflormethine Orinithine
FFS	Farmer Field Schools
FIND	Foundation for Innovative New Diagnostics
HAT	Human African Trypanosomiasis
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
MoHs	Ministries of Health
MOU	Memorandum of Understanding
NGOs	Non-governmental Organizations
NTDs	Neglected Tropical Diseases
PATTEC	Pan African Tsetse and Trypanosomiasis Eradication Campaign
SIT	Sterile Insect Technique
SP	Strategic Plan
SS	Sleeping sickness
SWAps	Sector-wide approaches
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
WHO	World Health Organization

1. EXECUTIVE SUMMARY

Human African Trypanosomiasis (HAT) or sleeping sickness is a neglected zoonotic disease affecting poor, rural communities living in the tsetse fly-infested regions of Africa. It not only attacks people's health, but because it also affects livestock, causing lowered productivity and death, it ruins their livelihood. Annual losses in agriculture alone have been estimated at over US$5 billion (Budd, 1999). The disease is a major public health problem, with 100% fatality in untreated cases. Affected populations have limited access to diagnosis, and the standards and effectiveness of case management are variable.

HAT is endemic in 36 African countries, including some of the least developed in the world. It occurs in discrete foci, ranging from small villages to districts, and has a tendency to flare up from time to time. The focal nature of the disease prevents HAT from attracting national attention, and allocation of resources for diagnosis and control is rarely done. In endemic countries, the situation is compounded by lack of advocacy for sustained action at national and community levels, in contrast to HIV/AIDS, for which concerted campaigning has yielded tremendous results in turning global and national attention to the disease.

When outbreaks of HAT occur, most governments are unable to respond quickly, either because there is no specific financial allocation for HAT control in the ministries of health (MoHs), or those who are responsible for allocating resources for management of the disease often do not understand the extent or implications of the problem. The situation is made worse by lack of commercially available diagnostic tests in the affected rural areas.

The decision to embark on the Pan African Tsetse and Trypanosomiasis Eradication Campaign (PATTEC) initiative generated the political goodwill that has contributed immensely to the achievements in trypanosomiasis control that are visible today. Yet many endemic countries still fail to give adequate priority to HAT in their health sector programmes, especially the sector-wide approaches (SWAps). The renewed interest and efforts to eliminate trypanosomiasis has created new demands for information on the epidemiology of HAT and has necessitated more frequent updating of available data on the distribution and burden of the disease, and the target population for diagnostics and drugs, in order to develop a global access strategy for these tools.

In line with the vision of PATTEC of an African continent free of the constraints of trypanosomiasis, the Foundation for Innovative New Diagnostics (FIND) has partnered with the AU-PATTEC to embark on a three-year collaborative project to intensify advocacy activities for African Trypanosomiasis (AT), which includes both the animal and human forms of the disease. This is aimed at:

- Urging governments of endemic countries to prioritize AT surveillance and control by ensuring adequate budgetary allocation
- Creating the environment necessary for the sustainable introduction of new diagnostic tests in the public sectors of endemic countries
- Increasing community awareness of the disease

Strategic objectives

1. To mount an intensified campaign for enhanced awareness and sensitization of HAT at local, national, regional and international levels.
2. To define a road map for advocacy that encourages endemic countries to put in place national policies and strategies for African Trypanosomiasis, as part of their general disease control programmes.
3. To urge governments, development partners and other stakeholders to allocate more resources for the elimination of AT.
4. To strengthen networking and partnerships for collaboration and advocacy among stakeholders.

The main outputs of this strategic plan include:

- Harmonization of current information on AT
- Coordination and regulation of AT control
- Increase in index of suspicion for HAT among health workers
- Improved health infrastructure
- Improved diagnosis and surveillance of HAT
- Enhanced awareness and ownership of initiatives to engage remedial action of AT problem at local, national, regional and international levels
- Development of action proposals for cooperation between governments of endemic countries and development partners
- Development of proposals for harmonization of national policies for intervention on HAT in endemic countries

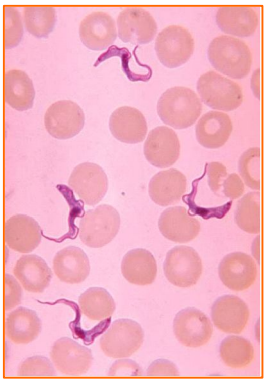
The activities will include: 1) Creation of partnerships to mobilize governments and communities in endemic areas, 2) Holding stakeholder workshops, 3) Preparation of documentaries and media briefings, 4) Conducting sub-regional meetings, 5) Providing training, and 6) Development, production and dissemination of advocacy materials.

Phase I of the Strategic Plan (SP) will be undertaken in eight countries namely: Angola, Democratic Republic of Congo (DRC), Sudan, Uganda, Côte d'Ivoire, Guinea, Nigeria and Tanzania.

The activities outlined in this SP, if well implemented, have the potential to increase the number of people under surveillance and therefore the number of HAT cases detected. The data generated will be used by FIND and its partners in developing a robust global access plan for HAT diagnostics. The plan will be tailored to each situation and designed to ensure sustainable access to HAT diagnostics, improved management and possible elimination of the disease.

2. BACKGROUND INFORMATION

Human African Trypanosomiasis



Human African Trypanosomiasis (HAT) or sleeping sickness (SS) is caused by trypanosomes, which are transmitted by tsetse flies (of the genus *Glossina*). The disease presents in two forms: a chronic form caused by *Trypanosoma brucei gambiense*, which occurs in west and central Africa, and the acute form, caused by *Trypanosoma brucei rhodesiense*, which occurs in eastern and southern Africa. The chronic infection, if left untreated, lasts for years while the acute disease may take only weeks before death occurs. The epidemiology of HAT is complex, and transmission cycles are subject to interactions between people, tsetse flies and trypanosomes, and significantly, in the *T.b. rhodesiense* disease, domestic and wild animals as well. In the *T.b. gambiense* disease, the classical human–fly-human transmission cycle occurs in both endemic and epidemic situations. Infected individuals, who remain undiagnosed due to inadequate surveillance and/or the limitations of current diagnostic tools in demonstrating low levels of trypanosome infections, act as reservoir hosts for this form of disease.

Sleeping sickness is a re-emergent disease, which belongs to the category of Neglected Tropical Diseases (NTDs). The disease occurs in 36 sub-Saharan African countries, within the area of tsetse fly distribution. According to the World Health Organization (WHO)'s global burden of disease estimates, HAT caused 1.5 million disability adjusted life years (DALYs) in 2002, which ranks it much lower than most infectious diseases in Africa but high among parasitic diseases (WHO, 2004). Over 60 million people living in some 250 foci are reported to be at risk of contracting the disease. In 2000, the WHO estimated that approximately 50 to 60 million people in Africa were exposed to the disease, while about 300,000 were affected. The estimated number of cases diagnosed and treated was estimated at 27,000. This is an obvious underestimate due to difficulties in diagnosis and remoteness of affected areas (WHO, 2002). With increased control efforts and populations under surveillance, the number of cases reported in 2005 had already reduced to 16,378 (Simarro *et al.*, 2008). The case fatality rate in untreated cases is 100%. This fact, combined with the focal nature of the disease, means that the DALYs averted per infection cured or prevented are very high. As a result, control of this disease in areas at risk is highly cost-effective, falling well below the accepted threshold value for money of US$25 per DALY averted.

At the beginning of the 20th Century, huge sleeping sickness epidemics devastated vast areas of the African continent. In the 1960s, prevalence of the disease had been successfully reduced to less than 0.1% in all endemic countries through the historic campaigns executed by the former colonial powers. Soon after independence, however, national governments failed to sustain such programmes due to lack or diversion of resources to other more pressing health problems. The breakdown of specialized mobile teams and health facilities in several countries, as a consequence of war and civic strife or change in health policy, resulted in dramatic resurgence of the disease, whose distribution corresponds closely with that of major conflicts in sub-Saharan Africa.

The social and economic impact of sleeping sickness is often underestimated. During epidemics, large proportions of communities are affected, with loss of life and untold suffering. These have serious social and economic consequences, which far outweigh the cost of maintaining surveillance. The disease has been a major cause of depopulation of large tracts of Africa. The fear it causes has led to abandonment of fertile lands, and is an impediment to development.

Several affected countries have agricultural-based economies and workers on cocoa and coffee plantations are at risk of contracting the disease, consequently reducing the labour force, since patients who must stay in bed/in hospital for a long time are unable to work (Kuzoe, 2001; WHO, 1998). This is reinforced by the fact that the disease mainly afflicts the active adult population. Regular medical surveillance, involving accurate case detection and appropriate treatment, and tsetse control where applicable, is the strategy for disease management. Experience has shown that where control is interrupted for a variety of reasons, resurgence of the disease occurs sooner or later.

African Animal Trypanosomiasis

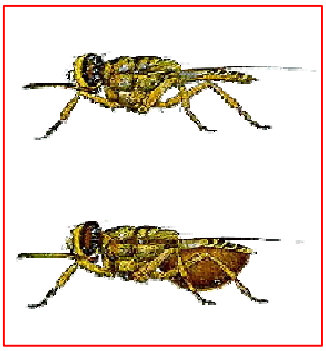
African Animal trypanosomiasis (AAT), also known as *nagana*, is a major constraint to livestock production and affects economic development and settlement in tropical Africa (Swallow, 2000). It is estimated that US$1.3 billion is lost per year in direct losses. Overall, agricultural production losses are estimated at US$5 billion (Budd, 1999). The animal disease is associated with very serious economic consequences such as livestock death, reduction of productivity (e.g. reduced milk, meat and draught power), fertility and conception as well as increased abortion, poor calving rates, and high treatment costs.

In addition, some animals act as reservoir hosts, thus playing an important role in sustaining endemicity and re-emergence of sleeping sickness epidemics in humans. In the case of *T.b. rhodesiense* disease, a number of wild and domestic animal reservoir hosts have been identified and certain outbreaks brought under control by treating cattle.

Although natural infections with *T.b. rhodesiense* have been reported in domestic animals such as pigs, dogs, sheep and cattle, and may occur in wild animals as well, the role of an animal reservoir in the epidemiology of *T.b. gambiense* sleeping sickness remains undetermined. Another important group of reservoir hosts, especially in *T.b. gambiense* epidemiology, are human carriers. These are infected individuals who remain undiagnosed due to inadequate surveillance and/or the limitations of current diagnostic tools in demonstrating low levels of trypanosome infections.

Vectors of Trypanosomiasis

Tsetse flies depend on blood to obtain nutrients. Different species of *Glossina* have different preferences for the source of their blood meal, with some specifically preferring human blood and are therefore important vectors of the disease in human populations. Both male and female flies feed on blood and thus serve as vectors of trypanosomes. The distribution of African trypanosomiasis is completely linked to the range of its vector, the tsetse fly. Due to the tsetse fly's climatic restrictions, the disease is restricted between the 14th latitude North and the 29th latitude South on the African continent. There are 29 species and subspecies of tsetse, divided into three groups with contrasting ecological and behavioural characteristics. First, the *Morsitans* group is found mainly in savannah woodlands across sub-Saharan Africa. The group includes the economically important vectors of animal trypanosomiasis, namely, *G. pallidipes*, *G. morsitans* subspp., *G. longipennis* and *G. austeni*. Second, the *Palpalis* group comprises species found mainly in the riverine woodlands of west and central Africa. The group includes important vectors of human sleeping sickness such as *G. fuscipes* and *G. palpalis* subspp. Third, the *Fusca* group comprises species typically found in humid forests. Some species (e.g., *G. brevipalpis*) have been implicated as significant vectors of animal trypanosomiasis (Torr *et al.,* 2007).



Tsetse flies thrive at humid temperatures of 25-26°C. Their breeding sites in East Africa are dry sandy beaches, under the shade of dense vegetations, under leaf litter in thickets/forests or under *Lantana* spp. or *Euphorbia* spp. hedges. In West, and Central Africa, HAT is transmitted by riverine tsetse species of the *Palpalis* group. These tsetse flies feed preferentially on man, especially where man-fly contact is high, such as at water collection and bathing points and river crossings. For the riverine tsetse species, man provides the reservoir of infection, although wild and domestic animals may play a minor role in particular foci. However, in East Africa, the epidemiology is different in that *T. b. rhodesiense* is transmitted by *G. fuscipes fuscipes* and domestic cattle are the main reservoir (Mbulamberi, 2001).

A range of tools for the control of tsetse flies have been applied over the last twenty years. These included bush clearing to eliminate the shaded places where tsetse rest and lay their larvae, and extensive destruction of wild game to eliminate blood sources used by tsetse flies. These methods are no longer in use. Ground spraying was also used but was discouraged due to its deleterious environmental effects. Sequential aerial technique (SAT) using ultra low dosages of biodegradable insecticides, use of traps, targets and live baits as well as the sterile insect technique (SIT) are among other tsetse control methods that are still in use.

Diagnostics in surveillance and control of sleeping sickness

Early diagnosis and treatment of HAT is critical since treatment of late stage disease is associated with high mortality. Furthermore, timely treatment interrupts the parasite's transmission cycle. However, early detection and treatment is not easy to achieve in many rural areas of Africa, where the first symptoms of the disease are easily confused with those of other common infections such as malaria and influenza (Jordan, 1986).

Diagnosis of sleeping sickness requires confirming the presence of the parasites in the blood, lymph node fluid or cerebrospinal fluid. Nonetheless, the disease is difficult to diagnose early due to both a lack of specific signs and symptoms in the first stage of the disease and the low sensitivity of available parasitological techniques. This is complicated further by the remoteness of the sleeping sickness endemic areas, which are characterized by poor infrastructure, including weak and/or non-existent health systems.

Presently, there is no screening test that is sensitive enough to guide treatment and those that are available are considered cumbersome. Diagnosis is followed by systematic stage determination by parasitological and biological examination of the CSF obtained by lumbar puncture, an invasive and painful procedure that is not well accepted by patients.

Since early-stage sleeping sickness is difficult to recognize clinically, and late-stage disease often leads to the death of patients, the disease control strategy recommended by the WHO relies on systematic screening of at-risk populations using the card agglutination test for trypanosomiasis (CATT), and confirmation of the presence of parasites by microscopy. CATT is a method developed for the detection of specific antibodies against *T.b. gambiense*, and though quite effective, has some problems of sensitivity and specificity. No similar test is available for *T.b. rhodesiense*. Since microscopy is both laborious and insensitive, many patients go undiagnosed. In addition, the molecular-based tests that have been developed are impractical and difficult to maintain in endemic rural areas due to absence of developed infrastructure.

Socio-economic and behavioural impacts of HAT

The socio-economic and cultural impacts of HAT are often underestimated; however, a few studies (Kyhomuhendo, 1998; Bukachi, 2007; Robays *et al*., 2008) have tried to address them. If left untreated, HAT causes biological damage and leads inexorably to death; and even if treated, it can still leave major irreversible conditions. Patients develop functional incapacities that increase their dependence on outside help. Time and money spent in search of a cure may be a serious drain on a family's resources. At community and family levels, mental confusion, personality and behaviour changes, which often characterize central nervous system involvement in late-stage disease, are observed and sometimes lead to divorce and break-up in homes. This may also present an unfavourable climate for bringing up children, not to mention the associated stigmatization of sleeping sickness patients.

Sleeping sickness is mainly a disease of the poor, marginalized and rural populations who depend on their land and labour for a livelihood. It represents a major threat to socio-economic development because it mainly affects the most productive age group (15 to 45 years) and sustains the poverty-disease cycle. Sleeping sickness disrupts normal family life, reduces the household work force, is the cause of abortions, sterility and gynaecological disorders, all of which lead to stigmatization, reduced productivity, and lost income in hospital bills and transport costs (Hide, 1999; WHO, 1998).

Epidemics of HAT have serious social and economic consequences, which far outweigh the cost of maintaining surveillance. Studies in Uganda have demonstrated that HAT has adverse effects on the functioning of households, as described above. These include increased poverty and decreased agricultural activities, often leading to famine or lack of basic food security, disruption of children's education and generally reversal of role obligations, often increasing women's and children's burdens (Kyhomuhendo, 1998; Bukachi, 2007).

The debilitating nature of the disease poses more problems for women, who may be stigmatised and/or rejected by their spouses, even after recuperation. HAT also causes gynaecological disorders such as amenorrhea, which reduces the reproductive capacity of the population. Infected women also risk giving birth to a congenitally infected child (Aroke *et al*., 1998). In children, HAT has been reported to have an influence on their physical growth, intellectual development and attainment of sexual maturity (Kuzoe, 2001).

Problems related to treatment, particularly the severe social consequences of long-term hospitalisation, are important behavioural factors that contribute to risk of death from sleeping sickness, such as negative attitudes towards hospital treatment, sometimes leading to absconding and incomplete treatment (Kuzoe, 2001). Inadequate awareness of the disease could also create obstacles to effective treatment and control, thus perpetuating the adverse impacts on the community.

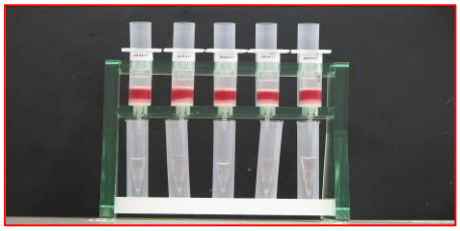
Drugs for sleeping sickness

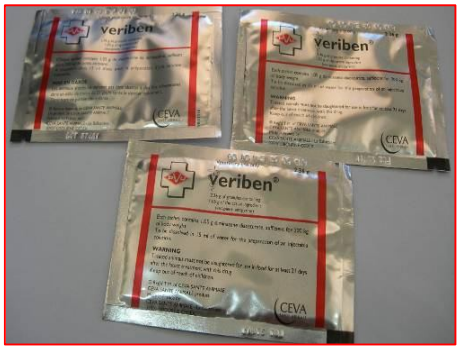
Treatment of sleeping sickness depends on the stage of the disease. The drugs used in the first stage of the disease are less toxic, easier to administer and more effective. The earlier the disease is detected, the better the prospect of a cure. Treatment success in the second stage depends on a drug that must cross the blood-brain barrier to reach the parasite. Such drugs are quite toxic and complicated to administer. Four drugs are registered for the treatment of sleeping sickness and are currently provided free of charge to endemic countries through a WHO private partnership with Sanofi-Aventis U.S. (Pentamidine, Melarsoprol and Eflornithine (DFMO)) and Bayer, AG (Suramin). Suramin is used for first-stage *T.b. rhodesiense*; Pentamidine for first-stage *T.b. gambiense* and Melarsoprol for the second stage of both forms of the disease. Eflornithine is only effective in the second stage of the *T.b. gambiense* (WHO, 2006).

The frequency and extent of use of the standard drugs for HAT, including melarsoprol and pentamidine, is likely to lead to development of resistance. Indeed, this has already been reported for Melarsoprol. In addition, Melarsoprol is associated with a reactive encephalopathy in up to 10% of treated patients that sometimes ends fatally. Furthermore, in Uganda, for example, the level of resistance to Melarsoprol has been reported in 30% of the patients treated with the drug. The availability of these drugs, and of DFMO, was not assured until recently. No new candidate drug is in the final stages of development. However, some trials in combination therapy are at advanced stages. These drugs are not only expensive (although they are currently available free of charge in an arrangement between the WHO and the pharmaceutical industry) but also require hospitalization for administration, a cost not covered by the providers of the drugs.

Control of Animal African Trypanosomiasis

Control of AAT is based on screening of animals and treating those that are found positive on a cost recovery basis. The main compounds used for the treatment of AAT are Diamidines (e.g. diminazene aceturate), Phenanthridium (e.g. homidium and isometamidium salts), Quinoline-pyrimidine (e.g. quinapyramine salts) and Napthalidines (e.g. suramin).





Block treatment has been done in situations of HAT epidemics due to *T.b. rhodesiense.* When livestock are used as live baits for tsetse control, they get some protection from tsetse fly bites and, to some extent, some trypanosome infections are averted.

Overview of the FIND HAT Diagnostics Programme

FIND is dedicated to the development of rapid, accurate and affordable diagnostic tests. Its vision is to make a difference in the quality of life for people who are constantly exposed to poverty-related diseases in the developing world. The mission of FIND is driven by the conviction that good health is central to winning the war against poverty, and that correct diagnosis is a crucial first step towards this goal. To achieve this mission, FIND employs best scientific and business practices and facilitates the development and appropriate use of improved diagnostic tests within public health systems, thereby helping to decrease global health inequities.

The purpose of the HAT diagnostics programme at FIND is to support development and evaluation of diagnostic tests for sleeping sickness. The programme takes cognisance of the fact that early diagnosis and treatment of HAT is critical, and that current diagnostic tools have limitations. Early detection with improved diagnostic tools helps avoid exposing patients to dangerous and expensive drugs, and delays in treatment. FIND therefore acknowledges that better diagnostic tools that are simple, accurate and robust would revolutionize HAT control, making mass screening in remote rural areas a realistic achievement.

For this reason, FIND is developing rapid, accurate and affordable point-of-care diagnostic tests for HAT and other poverty-related diseases that are endemic in the resource-limited settings. Since its launch in early 2006, the HAT diagnostics programme, implemented jointly with the WHO, has established linkages with industry, academic and research institutions in developed and endemic countries. Projects that are enabling the development of user-friendly diagnostic tests have been progressing well. The areas of emphasis include improvement in parasite separation from blood and cerebrospinal fluid, serological and molecular tests, and staging of the disease.

The diagnostic tools under development with the FIND support will be designed for use in the harsh field conditions that exist where most HAT cases are found. The development of point-of-care tests to direct treatment would greatly simplify patient care, allowing for earlier case detection, simpler management, and higher rates of cure. Early detection and treatment would remove prevalent cases from the population, disrupting transmission and improving disease control. Accurate diagnosis of HAT would also facilitate clinical trials on new drugs that are under development.

Overview of the PATTEC Programme

Africa's most viable contribution to her expanding population and to the rest of the world in the new millennium is increased agricultural productivity. The first step towards the development and realization of this ideal is the removal of the trypanosomiasis constraint. The Pan African Tsetse and Trypanosomiasis Eradication Campaign (PATTEC) was initiated following the escalating incidence of

trypanosomiasis that demonstrated the non-sustainability of past approaches to control the disease.

African Heads of State and Government meeting in July 2000 at the OAU (now African Union) Summit in Lome, Togo, passed a decision advocating for the eradication of the scourge of tsetse-transmitted diseases. The objective of trypanosomiasis eradication was made the collective responsibility of African countries, while the African Union Commission was entrusted with the responsibility of initiating, coordinating and leading a Pan African tsetse eradication campaign.

PATTEC is a concerted initiative of the African Union Member States, with the declared objective of eradicating the tsetse fly and trypanosomiasis from Africa within the shortest time possible. The initiative comprises an international campaign to generate the commitment, support and sustained action required for the eradication of trypanosomiasis from affected countries. The campaign is a collective, coordinated effort of African countries, set against a background of an urgent need to rid Africa of trypanosomiasis, and the constraints and suffering the disease imposes on the continent.

The initiative employs an area-wide approach that integrates a variety of tsetse suppression methods, including odour-baited traps, insecticide-treated targets, pour-ons, application of ultra-low volume insecticides by aerial or ground spraying and the sterile insect technique to achieve total elimination of tsetse and trypanosomiasis.

The PATTEC initiative advocates a systematic and sustained campaign to eliminate tsetse flies from individual zones of infestation and create an ever-expanding total tsetse-free area, until all areas in Africa will be tsetse-free. Intervention in the PATTEC Programme also includes the development of prescriptions for sustainable use of tsetse-free land.

Overview of the WHO Programme on HAT

In 2001, the WHO created a Global Alliance to eliminate sleeping sickness, bringing partners together to ensure coherence of efforts against the disease and maximize their effectiveness. Under WHO's leadership, NGOs, research institutes and national programmes meet regularly to share information and plan activities strategically. Existing networks are encouraged to exchange knowledge and information through the WHO, and a series of international training courses and regional meetings are organized and led by the WHO, both in Africa and Europe.

The WHO also continues to seek new partners willing to contribute their time, skills and resources to the programme's efforts to bring HAT once again under control, and to prepare for its ultimate elimination on the continent of Africa.

The strategic approach of the WHO is to coordinate, motivate and support all actors in the fight against HAT and to promote team spirit. To this end, the WHO programme aims to:

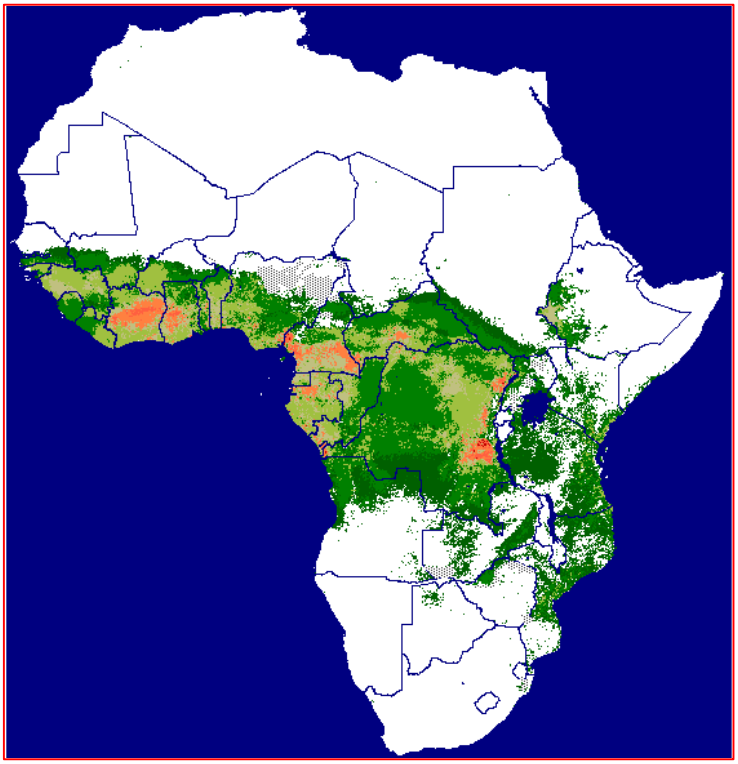
- Support all people dealing with HAT surveillance and control

- Create the best conditions for all to develop the most efficient ways to work and to collaborate
- Convince more partners to become involved in the fight against HAT
- Through research, to find solutions to respond to HAT surveillance and control needs

The prime role of the WHO working with its partners, therefore, is to provide access to diagnosis and treatment for people at risk through country support at different levels, including:

- Improving all organizational aspects of HAT activities through technical assistance
- Maximizing human resources to carry out the activities through training
- Enhancing case detection, treatment and surveillance activities through supply of reagents, equipment, logistic support and drugs
- Raising sufficient funds through advocacy and partnerships

The WHO is implementing a control and surveillance programme for HAT, and has created strong linkages with national control programmes, international organisations, research institutions, development agencies, NGOs and private firms participating in the management of human and animal trypanosomiasis. The objective of the network is not only to improve control tools, but also develop approaches that facilitate the integration of surveillance and control into primary health care structures, in order to ensure sustainability of field activities.



3. SWOT ANALYSIS

Strengths

The political goodwill of African Heads of State and Government to invest in tsetse eradication and African Trypanosomiasis elimination has already cut a niche that will be seized and used for AT advocacy. Furthermore, the acceptance and presence of the PATTEC initiative in endemic countries provides a good entry point for the advocacy activities on AT. Successful implementation of the Strategic Plan on AT advocacy no doubt requires synergy from all relevant stakeholders. The existing partnership between governments, development partners and relevant organizations should be enhanced and used as entry points for AT advocacy. The same applies to the existing health infrastructure (human and physical), already in place in many endemic countries. The benefits of advocacy are evident in the successful control of other diseases. Advocacy for control of AT and its subsequent elimination can also be achieved by exploiting the infrastructure created for the "big three" (Malaria, HIV/AIDS and TB). Thus, advocacy initiatives on AT can borrow a leaf from the advocacy approaches used for these diseases, and build upon the strengths already realized to achieve its goals.

Weaknesses

The accurate burden of AT is largely unknown, due to its changing dynamics and the indefinite number of undetected and untreated cases. Lack of baseline information on the true AT situation in endemic countries makes its prioritization difficult, both at national and international levels. Human African Trypanosomiasis occurs in rural remote villages and affects poor rural populations. It therefore does not attract much attention from decision makers and the international community thus rendering it a neglected tropical disease. A low index of suspicion, and inadequate skills among the health care workers, also contributes to the poor ranking of AT. It is therefore necessary to use a standardized tool for collecting relevant data in endemic countries, which would in turn be used to generate indicators upon which implementation of the activities identified in this Strategic Plan can be gauged, monitored and evaluated. Furthermore, an accurate and dynamic account of the epidemiology of AT will provide a rational evaluation of the magnitude of the problem and the true population at risk; data for lobbying relevant ministries in endemic countries to prioritize and allocate resources to AT will be generated. African Trypanosomiasis control activities are currently not properly coordinated, occur on an *ad hoc* basis, and usually only as an emergency response. Sustainability of control requires inter-sectoral cooperation among departments undertaking the activities in endemic countries. At the regional level, harmonization and coordination of control activities is necessary if one is to successfully achieve the goal of elimination. The PATTEC Coordination Office on the advocacy drive

should use existing legislation set-ups to coordinate and harmonise control and advocacy activities at all levels.

Lack of national control programmes in some endemic countries contributes to minimizing the importance of AT as a priority disease and hence no budget is allocated for its control. Mainstreaming AT in the national health strategic plans and poverty reduction strategy papers will be key to encouraging governments to give AT the attention it deserves. For countries that have developed strategic plans, there is need to build capacity of staff through training and creation of awareness to enable them to implement the strategic plans effectively. While not unique to AT control, the problem of staff retention is a major hindrance to effective management of AT. A Scientific Working Group convened by the WHO in 2001 acknowledged the need for better incentives for health workers, research scientists and technicians.

Opportunities

Opportunities worth exploring for advocacy on AT exist, and should be exploited maximally for the goals of tsetse eradication and AT elimination to be achieved. Networks that are already in place provide a good platform. There is need, however, to explore a coordinating mechanism to harmonize advocacy activities within and between the networks in order to take advantage of their synergies. Furthermore, using existing channels such as websites, the media, school systems, CBOs, religious groups, academia, community leaders, human rights groups, and farmer field schools (FFS), among others, to disseminate information, can be effective tools for AT advocacy.

Implementation of this strategic plan will raise awareness on AT and cause it to be prioritized at the community, national, regional and international levels through lobbying to influence and facilitate resource mobilization. Mainstreaming information about AT in the primary school curricula will increase knowledge of the disease for school children and their families. A curriculum for in-service training and orientation for health workers will build their capacity to diagnose African Trypanosomiasis at all levels, especially at the primary healthcare level, and ultimately reduce the burden of AT.

Threats

The general lack of coverage of neglected tropical diseases, such as AT, in the media contributes to the low profile these diseases get in the arena of general knowledge. Increased news reporting could be a “significant background” to policy change. Providing ready access to information and excerpts of AT when needed is critical to improve coverage. Furthermore, creating coalitions or networks could help strengthen voices in the media, while forming collaborations with journalists could be a step towards sustained and innovative advocacy on AT.

African trypanosomiasis has been accorded little attention and priority by politicians and donors, essentially because it is a rural problem, which occurs only in Africa, and mainly affects the poor. However, its negative impact on the history and socio-economic development of individuals, households and communities in endemic countries has the potential of negating the achievements of one of the Millennium Development Goals of halving poverty and food insecurity by 2015. The low priority given to AT also reflects in resource allocation, unlike other competing health problems/diseases (Malaria, TB, HIV/AIDS) that are given more funding. Human rights approaches, public debates in schools, colleges and universities, billboards and advertisements in the media, can be useful methods to advocate for prioritization of the disease.

Sensitization and awareness creation campaigns that have been carried out in AT endemic foci have been done in an *ad hoc* and unsustainable manner. Implementing frequent, intensified and targeted advocacy activities will be critical in keeping people informed about the disease.

The problems of sustainability and ownership of tsetse and trypanosomiasis control activities that have been applied over the years have hampered the progress made and negated the gains achieved. Extensive and repetitive creation of awareness through mass media, stakeholder workshops, community meetings, policy briefs, participatory approaches among others, have the potential to enable countries and communities appreciate the adverse impact of AT and make informed decisions.

The current tsetse eradication campaign was initially threatened by skepticism among some stakeholders on its reality and eventual elimination of AT from Africa. However, highlighting past successes in tsetse eradication e.g. Zanzibar, Namibia and Botswana, and including this information in advocacy materials and meetings, using innovative ways of advocacy through sports, tournaments, drama, goodwill ambassadors, radio talk shows among others, will re-emphasize the feasibility of eradicating tsetse and eliminating sleeping sickness.

Insecurity in some endemic countries due to civil conflicts poses a formidable challenge to disease control, as surveillance activities and control programmes are abandoned, while some regions become inaccessible.

4. VISION, MISSION AND VALUES

Vision

An African continent that is free of trypanosomiasis, and with an economically vibrant and healthy population

Values

Implementation of the activities identified in this Strategic Plan will be guided by the following shared core values:

- Good health is an essential foundation for social and economic development and access to basic health care is a human right. "The enjoyment of the highest attainable standards of health is a fundamental human right."
- Social, economic and gender inequities are major impediments to improvements in health.
- Knowledge is a crucial element in health improvement, and the attainment of self-reliance in research and development in disease endemic countries is a key to sustainability.
- Bridging the global gap in research and product development between the rich, and the poor and marginalized populations suffering from neglected infectious diseases, requires collaboration and partnership between public and private sectors, and the involvement of research, planning and implementing agencies at international, national and local levels, as well as of the targeted populations or communities.
- Elimination of HAT is technically feasible and economically justifiable as one of the important initial steps in Africa's efforts to alleviate poverty.
- Cost-effectiveness and efficiency in the application of human, physical and financial resources in a transparent and accountable manner.
- Creativity and innovation in the development of diagnostics and drugs for HAT in a pro-active process.

Mission

To create sustained attention and action at local, national, regional and international levels for sustainable access to diagnostic tests for sleeping sickness, and the elimination of the disease

5. GOAL

Objectively Verifiable Indicators

- Incidence of HAT reduced by 20% in endemic countries by month 36.
- Budgetary allocation for HAT activities in endemic countries increased by 100% by month 36.
- Index of suspicion for HAT, among health workers, increased by 50% by month 24.
- HAT is mainstreamed in health programs in endemic countries by month 36.

Means of verification

- WHO reports
- In-country HAT surveillance reports
- In-country budget returns
- In-country Ministry of Health reports

Important assumptions

- Political goodwill sustained
- There is adequate cooperation among key stakeholders in endemic countries

6. STRATEGIC OBJECTIVES

This Strategic Plan for African Trypanosomiasis Advocacy sets out the following strategic objectives for the planning period 2008-2011:

OBJECTIVES

1. To mount an intensified campaign for enhanced awareness and sensitization of HAT at local, national, regional and international levels.

2. To define a road map for advocacy that encourages endemic countries to put in place national policies and strategies for African trypanosomiasis, as part of their general disease control programmes.

3. To urge governments, development partners and other stakeholders to allocate more resources for the elimination of African trypanosomiasis.

4. To strengthen networking and partnerships for collaboration and advocacy among stakeholders.

7. OUTPUTS

OUTPUT 1

Current information on HAT harmonized

Objectively Verifiable Indicators

Current information on HAT gathered and documented by end of month 6.

Means of verification

- Project report on current status of HAT in Africa
- List of Contact Persons in endemic countries
- A template for data collection
- Database on HAT

Important assumptions

- Appropriate Contact Persons in endemic countries identified
- Cooperation by endemic countries

STRATEGY 1.1 — Identification of Contact Persons to collect and update data and information

Milestones: 8 Contact Persons identified by month 3

TASKS:

- Consultations with government officers in HAT endemic countries
- Interviews with potential Contact Persons

STRATEGY 1.2 — Development of templates for data collection

Milestones: Templates for data collection developed by end of month 3

TASKS:

- Designing and sending templates for data collection to Contact Persons.

STRATEGY 1.3 — Gather and verify available information on entomological, parasitological, socio-economic, environmental, land-use, diagnostic, treatment information, and assess capacity in endemic countries.

Milestones: Entomological, parasitological, socio-economic, environmental, land-use, diagnostic, treatment information gathered, and capacity documented by month 6

TASKS:

- Data gathering and recording by Contact Persons
- Synthesis and interpretation by PATTEC

STRATEGY 1.4 — Create HAT page on current AU website

Milestones: HAT page created on current AU website by month 3.

TASKS

- Gathering and synthesis of information on HAT by PATTEC
- Uploading HAT information on AU website

STRATEGY 1.5 — Develop a dynamic database for HAT.

Milestones: A dynamic database on HAT developed and hosted on the web by month 6

TASKS

- Gathering of data by Contact Persons
- Procurement of a dynamic database system by PATTEC
- Capturing and hosting of data on the web by PATTEC

OUTPUT 2

Control of HAT coordinated and harmonized

Objectively Verifiable Indicators

- Six joint planning meetings by month 36
- Common approaches employed in endemic countries by month 36
- Common protocols for diagnosis and treatment adopted by month 24

Means of verification

- Project report on current status of HAT in Africa
- Minutes of coordination/harmonization meetings
- Protocols for diagnosis and treatment

Important assumptions

- Adequate co-operation between endemic countries

STRATEGY 2.1 — Identification of Contact Persons for coordination and harmonization of activities in endemic countries

Milestones Contact Persons are identified in endemic countries by month 3

TASKS

- Consultations with government officers in endemic countries
- Interviews with potential Contact Persons

STRATEGY 2.2 — Strengthen and harmonize coordination at local, national and regional levels

Milestones

- 5, 2 and 1 planning/coordination/harmonization meetings held at local, national and regional levels respectively by month 12

TASKS

- Planning meetings/workshops at local, national and regional levels

STRATEGY 2.3 — Harmonize tsetse eradication and HAT elimination interventions at national and regional levels.

Milestones

- Same as in Activity 2.2

TASKS

- Same as in Activity 2.2

STRATEGY 2.4 — Encourage harmonization of activities of existing regional networks

Milestones

- 2 regional meetings by month 12
- An electronic HAT forum for sharing experiences and information by end of month 3
- A quarterly newsletter written and circulated by month 4

TASKS

- Regional meetings facilitated by PATTEC
- Hosting an electronic HAT forum for information sharing
- Newsletter development and circulation for information sharing

OUTPUT 3

Index of suspicion for HAT among health workers increased

Objectively Verifiable Indicators

- Number of people referred for HAT diagnosis increased by 33% by month 12, 66% by month 24 and 100% by month 36
- Number of HAT cases diagnosed correctly increased by 33% by month 12, 66% by month 24 & 100% by month 36

Means of verification

- Hospital records
- Laboratory records
- Survey reports - interviews with patients

Important assumptions

- Identification of the right health care personnel
- Knowledge will translate into action

STRATEGY 3.1 — Improve the ability of health workers at all levels including private clinics and traditional healers to suspect HAT

Milestones

- 2 in-country in-service trainings/refresher courses undertaken per country by month 12

TASKS

- Conducting in-service training
- Undertaking refresher courses
- Orientation

STRATEGY 3.2 — Mainstreaming HAT in the health training curricula

Milestones

- 4 meetings with Ministry of Health and Ministry of Education officials in endemic countries by month 12

TASKS

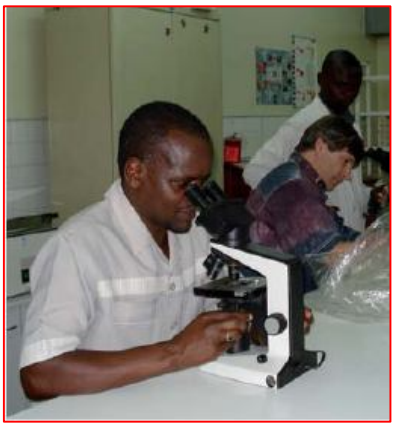
- Lobbying with Ministries

OUTPUT 4

Health infrastructure improved

Objectively Verifiable Indicators

- Budgetary allocation to HAT health infrastructure increased by 66% by month 24 and by 100% month 36
- 4 meetings with the Ministry of Finance and Ministry of Health personnel by month 12



Means of verification

- In-country reports
- Minutes of meetings

Important assumptions

- Political goodwill will be sustained
- Co-operation between countries sustained

STRATEGY 4.1 — Increase budgetary allocation for HAT control

Milestones

- Budgetary allocation for HAT control increased 66% and 100% by month 24 and 36 months respectively
- 4 meetings with Ministry of Finance and Ministry of Health officials by month 12
- 2 meeting with the donor community by month 12

TASKS

- Lobbying governments
- Fund raising with donors

STRATEGY 4.2 — Encourage cooperation, where possible, in the use of disease management facilities within and between countries

Milestones

- MOU for cooperation/sharing facilities, where possible developed between countries by month 24
- 2 regional meetings by month 12

TASKS

- Development of MOU for sharing of facilities
- Regional meetings
- Awareness and exchange of information

STRATEGY 4.3 — Utilization, where possible, of infrastructure for other ongoing health programme, e.g. Malaria, HIV-AIDS and TB, for HAT control activities

Milestones

- 2 joint planning meetings held at country level with Ministry of Health officials & program leaders by month 12

TASKS

- Meeting for planning and sharing experiences
- Consultations

OUTPUT 5

Diagnosis and surveillance of HAT improved

Objectively Verifiable Indicators

- Number of health facilities using available diagnostic tools properly increased by 33% by month 12
- Number of trained health personnel increased by 66% by month 24
- Number of HAT cases referred increased by 33% by month 12
- Uptake of novel diagnostic tools increased by 66% by month 24

Means of verification

- Surveillance reports
- Hospital reports
- Laboratory records

Important assumptions

- Access to available diagnostic tools

STRATEGY 5.1 — Improved capacity for the utilization of available diagnostic tools

Milestones

- 3 in-country trainings on current and novel diagnostics undertaken by month 12
- Access to diagnostic tools increased by 10% month 12
- Budgetary allocation for diagnostic tools increased by 33% by month 12
- 4 meetings with Ministry of Finance and Ministry of Health officials by month 12

TASKS

- Training on diagnostics
- Procurement of diagnostic tools
- Lobbying governments

STRATEGY 5.2 — Create environment for sustainable introduction of novel diagnostic tools in public sectors of endemic countries

Milestones

- 4 meetings with Ministry of Finance and Ministry of Health officials by month 12
- 3 in-country trainings on new diagnostics undertaken by month 12
- 2 meetings with charitable organizations and the private sector by month 12

TASKS

- Lobbying governments
- Training on diagnostics
- Lobbying pharmaceuticals local & foreign industries
- Lobbying charitable organizations & the private sector

STRATEGY 5.3 — Apply early warning systems in predicting HAT outbreaks

Milestones

- Data from passive surveillance updated monthly
- 4 active surveillance surveys undertaken on established sentinel areas by month 12
- Data from active surveillance surveys updated quarterly

TASKS

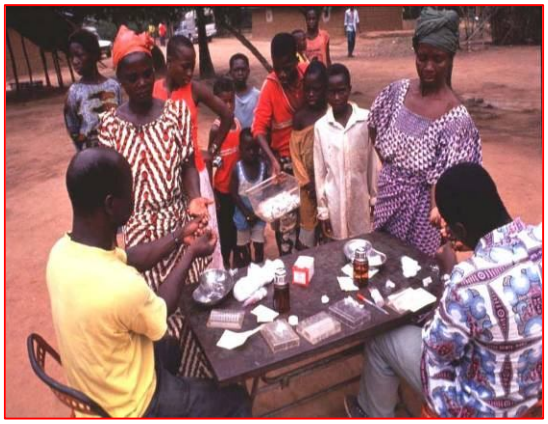
- Use passive surveillance data to develop an early warning system
- Establish sentinel surveillance posts in old HAT foci
- Undertaking active surveillance
- Uploading data into the dynamic database

OUTPUT 6

Awareness and ownership of HAT problem at local, national, regional and international levels enhanced

Objectively Verifiable Indicators

- Number of people demanding HAT diagnostic services increased by 33% by month 12
- 5, 3, 2 and 1 awareness meetings held at local, national, regional & international levels respectively by month 12



Means of verification

- Hospital records
- Survey reports
- Government reports
- Minutes of awareness meetings

Important assumptions

- Knowledge will be translated into action
- Cooperation among stakeholders

STRATEGY 6.1 — Intensify efforts to increase awareness at local, national, regional and international levels.

Milestones

- 5, 2 and 1 sensitization meetings held at local, national and regional/international levels respectively by month 12

TASKS

- Sensitization meetings at local, national, regional and international levels

STRATEGY 6.2 — Training of trainers

Milestones

- Identification of Trainers of trainers in endemic countries by month 2
- At least 3 Trainers of trainers from each HAT endemic country trained by month 5

TASKS

- Consultations with Contact Persons/other stakeholders in identification of trainers of trainers
- Training workshops

STRATEGY 6.3 — Establish linkages with appropriate resource centers for specific HAT activities

Milestones

- Identification of relevant resource centres by month 2
- 4 consultative meetings held with heads/officials of relevant resource centres by month 6
- At least one MOU developed with a resource centre by month 6

TASKS

- Consultation with Contact Persons and relevant stakeholders for identification of relevant resource centres
- Meetings with resource centre personnel
- Development of MOU

STRATEGY 6.4 — Identify, collect and evaluate for appropriateness, produce and disseminate advocacy materials

Milestones

- Identification and collection of advocacy materials by month 2
- Evaluation of relevant advocacy materials by month 4
- Production of advocacy materials by month 6
- Dissemination of advocacy materials by month 12

TASKS

- Collection of materials
- Evaluation of material for appropriateness
- Revision/development of new materials
- Production of materials
- Dissemination of materials

OUTPUT 7

Action proposals for cooperation between governments of endemic countries and development partners developed

Objectively Verifiable Indicators

- Draft guidelines on engagement between governments and development partners developed by month 12
- Guidelines adopted by governments by month 24
- Guidelines implemented in endemic countries by month 36

Means of verification

- Minutes of joint meetings
- Government reports
- Drafts of guidelines
- Adopted guidelines

Important assumptions

- Availability of well trained technical personnel
- Cooperation from development partners

STRATEGY 7.1 — Develop guidelines on engagement between governments of endemic countries and development partners

Milestones

- Guiding principles on engagement drafted and circulated by PATTEC by month 3
- 4 meetings held between governments and development partners by month 12
- Draft guidelines on engagement developed between governments of endemic countries and development partners by month 12
- Draft guidelines on engagement adopted by governments of endemic countries by month 24
- Guidelines on engagement implemented by governments of endemic countries by month 36

TASKS

- Drafting guidelines by PATTEC
- Joint planning meetings between governments and development partners
- Joint project development by governments and development partners
- Joint supervision of activities by governments and development partners
- Exchange of information between governments and development partners

OUTPUT 8

Proposals for harmonization of national polices on HAT in endemic countries developed

Objectively Verifiable Indicators

- Draft harmonized policy guidelines on HAT developed and circulated by PATTEC by month 3
- Harmonized national policy on HAT drafted in endemic countries by month 12
- Harmonized national policy on HAT adopted in endemic countries by month 24
- Harmonized national policy on HAT implemented in endemic countries by month 36

Means of verification

- Government reports
- Draft harmonized policy guidelines on HAT
- Policy documents

Important assumptions

- Availability of expertise
- Existing political goodwill is sustained

STRATEGY 8.1 — Prepare a framework that will guide endemic countries in the development of national policies on HAT

Milestones

- Draft framework developed and circulated by PATTEC to governments of endemic countries by month 3

TASKS

- Preparation & circulation of framework to endemic country governments by PATTEC
- Consultations with national stakeholders

STRATEGY 8.2 — Urge governments to develop and implement harmonized national policies and strategies on HAT

Milestones

- 4 meetings with the Ministry of Planning and Ministry of Health officials by month 12

TASKS

- Lobbying governments

8. MONITORING AND EVALUATION

ACTIVITY — Monitoring and evaluation
Milestones: 2 evaluations of the project undertaken by month 12
TASKS

- Review of project documents

ACTIVITY — TAG meetings
Milestones: Four meetings per year
TASKS

- Meetings

ACTIVITY — Stakeholders meetings
Milestones, One meeting per year
TASKS

- Meetings

9. PARTNERS AND STAKEHOLDERS FOR AT ADVOCACY

LOCAL LEVEL

1. **Opinion leaders (local administration and gatekeepers; politicians):** They will act as entry points for advocacy activities, and be the key focus for mobilization of people and resources and medium for dissemination of advocacy activities.
2. **Schools in endemic countries:** These will be one of the means for dissemination of advocacy information and materials.
3. **CBOs/NGOs:** These will create community awareness and serve as entry points for dissemination of advocacy activities and mobilization of people and resources.
4. **Informal health practitioners:** These will act as entry points for advocacy activities and media for dissemination of advocacy information.

NATIONAL LEVEL

5. **Governments and ministries in endemic countries:** These will act as entry points for dissemination of advocacy activities and information. They will also be targeted as sources of support for implementation of the AT advocacy activities and source of mobilization of people and resources.
6. **National trypanosomiasis control programmes:** These will be targeted for advocacy and support for enhanced efficiency.
7. **National and regional research and academic institutions:** These will be sources of expertise, information and data on HAT.
8. **National and regional trypanosomiasis networks:** These will act as media for dissemination of HAT advocacy activities.
9. **Clinical programmes in HAT and other diseases e.g. Malaria:** These will be targeted for advocacy and sharing of information, experiences and existing infrastructure.
10. **NGOs:** These will create community awareness and also act as entry points for dissemination of HAT advocacy activities and mobilization of people and resources.
11. **Private Sector:** These will be targeted for dissemination of HAT advocacy information and also as sources of support (e.g. resource mobilization).
12. **Clubs (Lions, Rotary, 4-K Clubs, etc):** These will serve as entry points for dissemination of HAT information and mobilization of people and resources.

INTERNATIONAL LEVEL

1. **International non-profit organizations:** These will be targeted for provision of data, global policy guidelines and linkages with other AT-related programmes on HAT. They will also act as sources of expertise and resources.
2. **Multinational companies:** These will be targeted for the provision of resources and support e.g. provision of diagnostic tools and AT drugs.

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ANNEX 1: WORKPLAN

WORKPLAN FOR HAT ADVOCACY ACTIVITIES (2008-2011)

	YEAR1												YEAR2												YEAR3											
	Q1			Q2			Q3			Q4			Q1			Q2			Q3			Q4			Q1			Q2			Q3			Q4		
Establish FIND / PATTEC Office																																				
MOU signed between FIND & AU/PATTEC																																				
Appointment of Advocacy Officer																																				
Equipment and operation of FIND/PATTEC office																																				
Appointment of Technical Advisory Group (TAG)																																				
OUTPUT 1: Current information on HAT harmonized																																				
1.1 Identify Contact Persons to collect & update data & information																																				
1.2 Develop templates for data collection																																				
1.3 Gather & verify available entomological, parasitological, socio-economic, environmental and land-use information, & assess diagnostic & treatment capacity in endemic countries																																				
1.4 Develop a dynamic database for HAT																																				
1.5 Create HAT page on AU website																																				

OUTPUT 2: HAT control coordinated and harmonized
2.1 Identify Contact Persons for coordination & harmonization activities in endemic countries
2.2 Strengthen coordination mechanisms for tsetse eradication & HAT elimination at local, national & regional levels
2.3 Harmonize tsetse eradication & HAT elimination interventions at national & regional levels
2.4 Encourage harmonization of activities of existing regional networks
OUTPUT 3: Index of suspicion for HAT among health workers increased
3.1 Improve ability of health workers to suspect HAT at all levels, including private clinics & through traditional healers in endemic areas
3.2 Mainstream HAT in health training curricula
OUTPUT 4: Health infrastructure improved
4.1 Increase budgetary allocation for HAT control

4.2 Encourage cooperation, where possible, in use of disease management facilities within & between countries
4.3 Utilize where possible, infrastructure for ongoing health programmes, e.g. Malaria, HIV-AIDS and TB, for HAT control activities
OUTPUT 5: Diagnosis & surveillance of HAT improved
5.1 Strengthen capacity for use of available diagnostic tools
5.2 Create environment for sustainable introduction of novel diagnostic tools in public sectors of endemic countries
5.3 Apply early warning systems to predict outbreaks of HAT
OUTPUT 6: Awareness and ownership of the problem of HAT at local, national, regional and international levels enhanced
6.1 Intensify efforts to increase awareness at local, national, regional & international levels
6.2 Training of trainers

6.3 Establish linkages with relevant resource centres for specific HAT activities																																	
6.4 Collect, evaluate, identify, produce and disseminate advocacy materials																																	
OUTPUT 7: A guiding framework for cooperation between governments of endemic countries and development partners developed																																	
7.1 Develop guidelines on engagement between governments of endemic countries & development partners																																	
OUTPUT 8: A roadmap for national polices on HAT in endemic countries developed																																	
8.1 Prepare a framework that will guide endemic countries in development of national policies and strategies on HAT																																	
8.2 Urge governments to develop & implement national policies on HAT																																	
Monitoring and evaluation																																	
Monitoring & Evaluation																																	
TAG meetings																																	
Stakeholders' meetings																																	

Annex 2: BUDGET

BUDGET (2008-2011)

ITEM	Estimated cost (USD)		
	YEAR1	YEAR2	YEAR3
OUTPUT 1: Secretariat costs			
Administrative Assistant	16,000	16,000	16,000
Desktop Publisher	18,000	18,000	18,000
Honorarium for Contact Persons (in 8 most affected countries)	24,000	24,000	24,000
Identification of Contact Persons in affected countries (Lump sum)	10,000		
Development of templates for data collection (7 consultant days)	3,000		
Gathering and verifying available information on entomological, parasitological, socio-economics and environment and land-use and diagnostic and treatment and capacity in all 37 endemic countries (Assuming 50% compliance to posted data collection instrument)	106,400		
Developing a dynamic database for HAT	12,000		
Creation of a HAT webpage on current AU website	3,000		
Collection, identification & production of advocacy materials	90,000		
Preparation of a framework to guide endemic countries in the development of national policies on HAT	5,600		
Monitoring and Evaluation	11,200	11,200	11,200
TAG meetings	66,000	66,000	66,000
Stakeholder meetings	80,000	80,000	80,000
TOTAL	**445,200**	**215,200**	**215,200**
OUTPUT 2: HAT control coordinated and harmonized			
2.1 Support for coordination activities	7,000	7,000	7,000
2.2, 2.3, 2.4 Workshops & meetings	19,000	19,000	19,000
OUTPUT 3: Index of suspicion for HAT among health workers increased			
3.1 Improve the ability of health workers to suspect HAT at all levels including private clinics and traditional healers in endemic areas	8,250	8,250	8,250
3.2 Mainstreaming HAT in the health training curricula	1,200	1,200	1,200
OUTPUT 4: Health infrastructure improved			
4.1 Increase budgetary allocation for HAT control	7,000	7,000	7,000
4.2 Encourage cooperation in utilization of disease management facilities within and between countries	3,000	3,000	3,000

4.3 Integration of HAT control activities in ongoing health programs e.g. Malaria, HIV-AIDS, TB	3,000	3,000	3,000
OUTPUT 5: Diagnosis & surveillance of HAT improved			
5.1 Strengthen capacity for the utilization of available diagnostic tools	10,500	10,500	10,500
5.2 Create an environment for sustainable introduction of novel diagnostic tools in public sectors of endemic countries	3,000	3,000	3,000
5.3 Apply early warning systems in predicting HAT outbreaks			
Passive surveillance	2,000	2,000	2,000
Sentinel surveillance - for 2 sites	6,000	6,000	6,000
OUTPUT 6: Awareness and ownership of HAT problem at local, national, regional and international levels enhanced			
6.1 Intensify efforts to increase awareness at local, national, regional and international levels	25,000	25,000	25,000
6.2 Training of trainers	6,300	6,300	6,300
6.3 Establish linkages with relevant resource centres for specific HAT activities	2,000	2,000	2,000
6.4 Dissemination of advocacy materials	10,000	10,000	10,000
OUTPUT 7: A guiding framework for cooperation between governments of endemic countries and development partners developed			
7.1 Develop rules of engagement between governments of endemic countries & development partners	3,000	3,000	3,000
OUTPUT 8: A roadmap for national polices on HAT in endemic countries developed			
8.2 Urge governments to develop and implement national policies on HAT	3,000	3,000	3,000
Total recurrent costs for 1 country	**119,250**	**119,250**	**119,250**
Total recurrent costs for 8 endemic countries	**954,000**	**954,000**	**954,000**
Secretariat costs	**445,200**	**215,200**	**215,200**
Total for Secretariat & recurrent costs for 8 countries	**1,399,200**	**1,169,200**	**1,169,200**

Annex 3: CRITERIA FOR SELECTION OF COUNTRIES

CRITERIA FOR SELECTION OF COUNTRIES FOR ADVOCACY ACTIVITIES

A list was made of HAT endemic countries based on Simmaro *et al*. (2008). Using the unpublished WHO document, the populations at risk of HAT and the number of HAT foci were identified for each country. The populations at risk and the number of HAT foci were multiplied to give the weight shown in column 4 in the table below. The rationale for this was to gauge the seriousness of the disease in a particular country. Countries with a weight above ten million were then selected, with a total of eight endemic countries chosen to participate in Phase 1 of the Strategic Plan.

Country	Population at risk	No of HAT foci	Weight	Decision	Serial number
Angola	3,000,000	19	57,000,000	Selected	1
DRC	10,000,000	34	340,000,000	Selected	2
Sudan	5,000,000	11	55,000,000	Selected	3
Chad	50,000	9	450,000		
CAR	100,000	9	900,000		
Congo	500,000	14	7,000,000		
Uganda	2,000,000	5	10,000,000	Selected	4
Cameroon	1,000,000	9	9,000,000		
Côte d'Ivoire	4,000,000	10	40,000,000	Selected	5
Equatorial Guinea	300,000	4	1,200,000		
Gabon	400,000	9	3,600,000		
Guinea	2,500,000	8	20,000,000	Selected	6
Nigeria	13,000,000	3	39,000,000	Selected	7
Tanzania	1,500,000	19	28,500,000	Selected	8
Malawi	1,200,000	4	4,800,000		
Zambia	500,000	6	3,000,000		
Kenya	700,000	2	1,400,000		

Annex 4: SUGGESTED STRATEGIES FOR INCREASED ADVOCACY

SUGGESTED AWARENESS CREATION STRATEGIES

1. Local level – sensitization through drama, village *barazas*, posters, films, video shows, radio talks, SMS, road shows, sports tournaments, frequent messages on HAT aired on local radio and TV stations, presentations on radio and TV geared for children and a younger public, composition of songs, poems, essays and drawing competitions in schools and colleges, lifecycle of trypanosomiasis and HAT on exercise book covers; branded pens, partnering with private sector for advocacy activities, using existing local organizations to disseminate HAT information (CBOs, FFS, women groups, faith based organizations), school clubs e.g. 4-K clubs; kindergarten rhymes; documentaries; T-shirts
2. National level – media briefings, policy briefs, stakeholder workshops
3. Regional level – Presentations at regional meetings
4. International level – HAT day

OPTIONS FOR ACCELERATED RESOURCE MOBILIZATION

1. Local level – e.g. labor mobilization through existing local structure e.g., CBOs, FFS, women groups, faith based organizations, community meetings; Community Development Fund – like initiatives
2. National level – media briefings, policy briefs, stakeholder workshops, public-private partnerships e.g. Safaricom, MTN, Zain, etc, social responsibility programs; celebrations; Sports persons; First Ladies
3. Regional level – Use of goodwill ambassadors, First Ladies, sports persons
4. International – Use of goodwill ambassadors; First Ladies; eminent persons

MEANS OF STRENGTHENING NETWORKS

A) Partnerships and collaboration; B) Participation in strategic joint activities such as joint awareness creation activities; C) Knowledge sharing to enhance synergy in HAT elimination

MEDIA TOOLS FOR ENHANCING ADVOCACY

Website; newsletters; audio-visual technologies (video clips; documentaries; etc); advertisements; billboards; briefs; pamphlets; brochures/banners; booklets; stickers.

ISSUES IMPORTANT FOR ACHIEVEMENT OF THE PROJECT OBJECTIVES

1. Materials for advocacy need to be designed by advocacy experts
2. Implementation of the SP needs to be informed by the fact that countries could be at different levels of human, financial, physical resource endowment and therefore may require special support particularly to establish health infrastructure, which the SP does not provide for.
3. Countries may have different socio-political, cultural and economic conditions which may require different levels of sensitivities and therefore different approaches in the implementation of the SP [e.g. focal point appointed from southern Sudan to lobby government in northern Sudan]

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