



One World-One Health and neglected zoonotic disease: Elimination, emergence and emergency in Uganda



James Smith ^{a, b, *}, Emma Michelle Taylor ^a, Pete Kingsley ^a

^a Centre of African Studies, Chrystal Macmillan Building, 15a George Square, University of Edinburgh, Edinburgh, EH8 9LD, UK

^b Department of Geography, Environmental Management and Energy Studies, University of Johannesburg, Johannesburg, South Africa

ARTICLE INFO

Article history:

Available online 24 June 2014

Keywords:

Uganda
Trypanosomiasis
One Health
Disease elimination
Health governance
Surveillance
Millennium Development Goals
Neglected Tropical Diseases

ABSTRACT

This paper traces the emergence and tensions of an internationally constructed and framed One World-One Health (OWOH) approach to control and attempt to eliminate African Trypanosomiasis in Uganda. In many respects Trypanosomiasis is a disease that an OWOH approach is perfectly designed to treat, requiring an integrated approach built on effective surveillance in animals and humans, quick diagnosis and targeting of the vector. The reality appears to be that the translation of global notions of OWOH down to national and district levels generates problems, primarily due to interactions between: a) international, external actors not engaging with the Ugandan state; b) actors setting up structures and activities parallel to those of the state; c) actors deciding when emergencies begin and end without consultation; d) weak Ugandan state capacity to coordinate its own integrated response to disease; e) limited collaboration between core Ugandan planning activities and a weak, increasingly devolved district health system. These interrelated dynamics result in the global, international interventionist mode of OWOH undermining the Coordinating Office for Control of Trypanosomiasis in Uganda (COCTU), the body within the Ugandan state mandated expressly with managing a sustainable One Health response to trypanosomiasis outbreaks in Uganda. This does two things, firstly it suggests we need a more grounded, national perspective of OWOH, where states and health systems are acknowledged and engaged with by international actors and initiatives. Secondly, it suggests that more support needs to be given to core coordinating capacity in resource-poor contexts. Supporting national coordinating bodies, focused around One Health, and ensuring that external actors engage with and through those bodies can help develop a sustained, effective OWOH presence in resource-poor countries, where after all most zoonotic disease burden remains.

© 2014 Elsevier Ltd. All rights reserved.

1. Introduction

The emergence of a “One World, One Health” (OWOH) framework as a guide for responses to Avian Influenza and other zoonotic diseases resonates with an especially global reading of health. OWOH, or any of its related hues, is not simply a component of coordinated international responses to emerging risks. Rather, it is a part of the emergence of an assemblage of international institutions, coordinating bodies, new organisational forms and policy initiatives that have coalesced and interact with, sustain, and promote particular ways of conceptualising, and doing, global health (FAO-OIE-WHO, 2010).

* Corresponding author. Centre of African Studies, Chrystal Macmillan Building, 15a George Square, University of Edinburgh, Edinburgh, EH8 9LD, UK.

E-mail addresses: james.smith@ed.ac.uk (J. Smith), e.m.taylor@ed.ac.uk (E.M. Taylor), Pete.kingsley@ed.ac.uk (P. Kingsley).

We are witnessing a period of unprecedented innovation within global health, and as innovation suggests new ideas and approaches, it also infers tension and discordance. New forms of partnerships, and new networks of interest groups and lobbies have emerged in response to massive philanthropy and the huge increases in donor aid that have been driven in part by the Millennium Development Goals (MDGs). These emergent organisational forms and new resource flows intersect with the traditional actors, the World Health Organization, the United Nations, multi-lateral and bilateral donors, and states, in both North and South.

This Global Health churn presents an opportunity for policy ideas that promise to capture and coordinate complexity, and this is a context in which OWOH and its variants, in their conceptual fungibility, were in retrospect always likely to prove influential (Chien, 2013). This conceptual flexibility is not limitless, however. It favours globally contagious disease, it promotes emergency intervention, it prioritises scale, and it values organisational and systems

capacity. In this article we intend to filter the global white noise of OWOH to focus on the local reality of attempts to operationalize a “One Health” approach to disease control in Uganda. In doing so we hope to interrogate the relationship between convergence and scale, about how global ideas around convergence and integrated approaches to zoonoses translate to the practicalities of national coordination and local activity.

To address this issue we draw upon insights gained from the literature on ‘global assemblages’ (Ong and Collier, 2005). Global assemblages describe the configurations through which global forms of techno-science, economic rationalism and expert systems gain significance and shape. The global assemblage is the tool for the production of global knowledge, in the sense of knowledge about global forms and knowledge that strives to replace socially, politically and spatially context-bound forms of knowledge. The composite term implies inherent tensions. Global implies homogeneity, intervention and mobility, while assemblage implies heterogeneity, contingency and context. Together, the term captures the articulation of evolving global forms into territorialized, emergent structures or domains that shape ideas, technologies and relationships.

An important subtext to global assemblages and other ideas that draw upon notions of techno-science is a reminder of the social and political nature of science, and by extension, technologies (Jasanoff, 2004). Thus, science and technology become important elements in the co-production of policy narratives that articulate particular policy problems, why they are important, and most importantly what should be done about them, and by whom (Dry and Leach, 2010). Here, we attempt to trace the lineage and articulation of OWOH approaches from the global to the local, in an effort to understand what OWOH means for a national coordinating body that is ostensibly trying to enact that very approach in a resource constrained environment, with the political, financial and technical challenges that entails.

This article will draw upon the case of contemporary efforts to coordinate the control and elimination of African Trypanosomiasis (AT) in Uganda, the archetypal colonial disease (Maudlin, 2006), which is now also labelled a ‘Neglected Tropical Disease’ (NTD). A recurring motif of AT research and control has been the “sheer intractability of the disease and its curiously localised incidence” (Tilley, 2011, p. 201), there are multiple challenges underlying methods of disease control for AT: the vector is difficult to control, what drugs are available are toxic and are thus dependent on a positive diagnosis, which in itself presents major technical problems (Brun et al., 2010).

The article presents three dimensions of intervention and interaction, each of which connects to an OWOH narrative. Firstly, the paper considers the global politics of health prioritisation, and how an emergent NTD lobby has grown in response, generating its own dialogues of neglect and ideal intervention. Secondly, we present the Stamp Out Sleeping Sickness (SOS) campaign, an initiative which is in many ways an exemplar of a public–private partnership, One Health approach, framed around an emergent threat and promising an integrated response. Thirdly, we describe an external ‘emergency response’ that took place towards Uganda’s border as infections rose. Taken together, these case studies illustrate how ‘One Health’ exerts conceptual traction in multiple ways, at multiple levels, to reinforce particular sorts of interventions. In the case of AT control in Uganda the result is that the concept undermines the long-standing One Health ambitions of the state, rather than supports them.

2. Methods

The empirical data cited in this article was collected in Uganda in February and April 2013. We undertook a series of qualitative

interviews with relevant policymakers, government officials, non-governmental organisation workers, scientists and academics. We attempted to interview people who represent all key organisations involved in Trypanosomiasis control in Uganda. We interviewed over 20 stakeholders.

We secured the informed consent of all interviewees. We have tried to strike a balance between preserving the anonymity of individuals and giving a sense of who people work for and what they represent. The research project underwent ethical review through the University of Edinburgh, and the research has research clearance as part of a broader University of Edinburgh project around NTD control in Uganda.

3. Global frames: One Health and NTDs

The MDGs gave new prominence to the health issues affecting the poor. However, the targets they provided were restricted and the result of top-down deliberation, rather than informed by inclusive analysis and/or the prioritisation of development needs. Consequently, the narrowly focused and largely sector-specific MDGs left gaps in coverage and failed to realise synergies between the foci covered by the goals (education, health, poverty and gender). MDG 6 in particular – *Combat HIV/AIDS, malaria and other diseases* – sidelined many of the communicable and non-communicable diseases that perpetuate the cycle of poverty in developing countries.

The very act of naming HIV/AIDS and malaria raised the profile of these diseases immeasurably, relegating everything else to ‘other diseases’ with attendant effects on funding and focus. The case of tuberculosis is instructive, however; campaigning and lobbying was so powerful that it is now widely assumed that it too received a particular mention in the MDG 6. Of course, tuberculosis, especially in its multi-drug resistant and extensively drug resistant forms, represents many of the biosecurity fears that resonate with the OWOH formulation of global health (Harper, 2010). There is traction in the transportability of risk. A nexus of networking, articulation and risk may blur the boundaries of the MDGs and raise the profiles of diseases and their prioritisation as objects of the apparatus of global health. The omission from MDG 6 stimulated an advocacy campaign to focus on a host of ancient infectious diseases, many of which are zoonotic, that disproportionately effect poor and marginalised populations. Historically, these diseases were viewed as discrete and tackled through multiple vertical programmes. Following the MDG snub a campaign was launched to argue for a number of diseases to be viewed as a cluster of 17 diseases under the rubric of NTDs. This has culminated in a series of global targets, partnerships and initiatives (cf. WHO, 2012; NTDs, 2012).

Thanks to this of triumvirate of committed global advocacy, substantial funding support from philanthropic and bilateral donors (especially from the UK and US) and increased commitments from pharmaceutical companies to provide drugs, there is now a much stronger sense of NTDs as a burden to be tackled. There is also a growing sense of a common approach to do so, at least for the seven NTDs (schistosomiasis, lymphatic filariasis, onchocerciasis, trachoma, and the soil-transmitted helminths) that are responsive to integrated control through widespread preventive chemotherapy, or Mass Drug Administration (MDA). Such programmes are often implemented via public–private relationships using control tools comprised of drugs that address multiple NTDs over large areas and populations. The MDA approach is articulated in terms of “small costs, huge benefits” (Molyneux et al., 2005, p. 1068). For example, a significant gain in morbidity rates can be obtained at a cost of less than \$0.50 per person per year (WHO, 2012).

Download English Version:

<https://daneshyari.com/en/article/952245>

Download Persian Version:

<https://daneshyari.com/article/952245>

[Daneshyari.com](https://daneshyari.com)