COMMUNITY DIRECTED INITIATIVES IN DISEASE PREVENTION AND CONTROL

The True Spirit of Alma Ata Declaration on Primary Health Care

Insight

Oct - Dec 04

Kanungu "Chief" Speaks about Onchocerciasis

Peace Habomugisha*

From a variegated background (social, political, geographical, temporal and much more), the reader is led to some keywords, the interview itself and, lastly, to the core of the main speaker's remarks.

Setting and Time

Elias Byamungu is the Chief Administrative Officer (CAO) of Kanungu District in the southwest of Uganda. The writer was scheduled to interview him on April 29, 2004 – the occasion of a regional review, in Kanungu town, of the treatment and control of onchocerciasis. The interview never took place as he had other more pressing commitments that day. Weeks later, on 19 May 2004, this reporter did, however, succeed in arranging another audience with him. Kampala, this time, was the venue of the question-and-answer session between the "chief" and the interviewer. Below, a shortened edition, of recordings of the meeting, comes to the reader. Why, you will likely ask, was he made the focus of this important interview? Everywhere in his constituency, Byamungu has been a powerful backer of policies and programs of community-directed treatment with ivermectin (CDTI). Thus, for one example, he has crisscrossed his district, in the company of our DOC for the domain, to sell our program goals to his subjects. When he is in Kampala, to cite one more, he makes it a point, again and again, to call at the national offices of The Carter Center Global 2000 to know the latest developments, in our plans and work, that may interest and benefit the people of Kanungu. The idea of limelighting him, did, indeed, arise when we realized that he was a great driving force in CDTI implementation in his area. The fact that he is the ultimate controller of his district's finances, did, also, make him a topic of much attraction and attention for our data collection and dissemination.

Kanungu "Chief" Mr. Elias Byamungu, speaks out

Key Terms

Qn. is an abbreviation of question while the acronym ans. means answer. As a matter of course, the reporter asks the questions to which the interviewee responds. Clar stands for clarifications made by Habomugisha – each of which provoked from Byamungu a response identified as bym for convenience sake. The former's clarifications, on the whole, have to do with issues of support from APOC. Clarifications aimed to bring Byamungu face

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to face with certain issues, to which there was no direct attention from him, in questions asked him minutes earlier.

The Interview

Qn.: Can you, please, give us a brief history of your work experience?

Ans.: I have been in Uganda's civil service for 18 years so far, working in various capacities and in districts like Bundibugyo, Fort Portal and Ntungamo. I worked in the Ministry of Local Government: There I gained experience as a national trainer for decentralization and this took me to all parts of the country. I became a deputy CAO in 2000 when I was posted to Ntungamo. I became a CAO in June of 2002 and started working in Kanungu in July of the same year.

Qn.: What have been your major challenges and strengths during the course of your work?

Ans.: My greatest challenge has been to open up closed places, which have not had a serious dosage of public investment, e.g. in Bundibugyo. There, there were no proper roads and no good houses. By the time I left, however, many good houses had been built; a good road had been constructed; and one can now take only 6 hrs from Fort Portal to Bundibugyo as opposed to the original 12-hour journey.

My strength is to simplify myself. If there is no electricity, I work without it; no flowing water, I manage with the little that is available but boil it. I also mobilized people to pressurize government to provide certain amenities through development projects, etc.

Qn.: How did you know about onchocerciasis?

Ans.: When I worked in Fort Portal there was a Basic Health Services Project run by the German Technical Cooperation agency (GTZ); and this was in 1988. It had a component of onchocerciasis control. That is where I learnt about river blindness, ivermectin, the effectiveness of the drug, etc. We were able to eradicate onchocerciasis in the forests of Mwenge and the valleys of Bundibugyo.

Qn.: What do you know about onchocerciasis?

Ans.: It occurs in places that have specific physical features such as deep valleys, which are long and with fast flowing waters and bushes with canopies. In there is the home of the blackfly, which is responsible for causing river blindness. If it were possible each district should have a functional vector control unit, part of whose work would be to gather these flies and determine how and when the health ministry and local government can and should intervene. I was taught that when the fly bites people, it takes some time before symptoms of the infliction, such as hardening of skin and its peeling off as if it has been burnt, appear. Some cases of it are similar to elephantiasis – the feet become so huge. Taking the ivermectin drug, early, can reduce these problems. It takes a long time to treat this malady: one needs to swallow the drug once a year for about 10 years or more. A tablet of the drug costs about $3 at factory price. This is not sustainable for our economies, especially among poverty-stricken communities. In effect, preventive measures, like those of Primary Health Care (PHC), are the best way to contain the disease. I understand the drug is also a good de-wormer and that is why we need to keep an eye on it in the stores. If no such security was provided and if the proper instructions of using it were not adhered to, children and others not supposed to take the drug would access it.

Qn.: After knowing that much about onchocerciasis how did it impact on you?

Ans.: There was an old man in my village, when I was growing up, who had an ailment resembling elephantiasis. Once I learnt about onchocerciasis, I decided to send him ivermectin. He was very excited and I was happy that I could create such change in him. Anything to do with blindness, talking generally, makes me scared stiff. After knowing about onchocerciasis and the problems it can cause people, I have had to be personally involved in activities for curbing the disease. Almost always, indeed, I push Kanungu's District Onchocerciasis Coordinator to carry out well his duties.

Qn.: What, however, are some of the specific roles that are played by you and your district in the combat of onchocerciasis?

Ans.: Social mobilization is one. I call all LC1s twice a year to

brief them about our achievements and challenges in the struggle. As a matter of accountability, I give them figures of how much was disbursed to their villages. This also influences them to demand accountability from their sub-county authorities.

Without fail, I ask people, in Kanungu's affected areas, to confirm that they receive ivermectin, to discourage users of the drug from opting out of the treatment and control scheme, and to always let me know if they are benefiting from the medical service.

The district's responsibility is to ensure that financial and other resources are mobilized in order to contribute to the onchocerciasis program: Each sub-county makes a token contribution. We still have a problem with the LC3s, though, because they do not prioritize onchocerciasis in their plan.

Qn.: What have you found fascinating about your involvement in those activities?

Ans.: Every time I call at a sub-county's head offices, I learn something new. For instance I recently discovered that some sub-county officials are extracting tax from sick individuals, including casualties of onchocerciasis. I instructed them to exempt these people. Rural peasants are open to a large extent; they do not hide many things. For example, if a man is impotent, he would say, "A sheep has stepped on me," entama ekandibata. The openness enables us to work out how best we can help them.

Looking on is the CAO at a workshop

Qn.: What have been the benefits of the onchocerciasis program in Kanungu?

Ans.: They are immense! I cannot compute them in monetary figures. The disease has declined tremendously. No new cases are coming up. Although we cannot measure them accurately, we can say, "We have almost eliminated this problem."

Qn.: What holes exist in the program?

Ans.: Our communication strategy is not without flaws. We produce bulletins but as you know some people have not cultivated a reading culture; so when they receive a bulletin, they just sit on it. Use of radio to communicate messages directly to the communities, as many people have personal wireless sets, which they only have to turn on to listen in to programs on the air, is one way of combating this. We could use the local FM radio station and have a health educator, or me, and other people to talk about problems of onchocerciasis. More attention would surely be paid by the public because such voices as mine are familiar to them. Different people, with great authority, would indeed make a difference through such air programs.

Another weakness is that onchocerciasis control is not yet fully integrated in the overall district development plan. It needs to be regarded and treated as a district activity and not a Global 2000 activity. Purchases of drugs by the District Medical Officer (DMO), for instance, should include ivermectin so that it becomes readily available from sub-health centers or from among designated distributors in the affected communities.

Facilities for trapping the blackfly is a need that is still largely unmet in Kanungu. This contrasts sharply with the experience I had in Fort Portal where we had

traps, which were used to collect insects and put them on charts. We were consequently able to monitor their behavior, their numbers, how they were multiplying themselves, and so on. The Ministry of Health apparently needs to see how to get traps for the onchocerciasis program, place them in the different areas where they are needed, and assign to certain individuals the business of tracking down the flies. The catch would then be taken for examination and analysis in various laboratories.

Qn.: Now that APOC has pulled out, what are you planning to do as a district to ensure that the program continues?[1]

Ans.: This is a challenge. Political leaders, who are pushing to remove graduated tax, are my major problem, however. I just request them to put very little pressure on the central government until there are alternatives. The problem with the tax is the significantly inhumane method of its collection. So many bad things happen when it is due. One time in Fort Portal, for example, an old woman was killed during an operation to enforce payment of graduated tax. In such other places as Ibanda and Kitagwenda, respectively in Mbarara and Kamwenge districts, when you hear people say, "It will rain tonight," it means there will be a crackdown on evaders of the tax. Defaulters, who are nearly always men, usually run away at this time. There ought to be other progressive methods of teaching and requiring people to contribute towards their development through taxation, otherwise without a tax base where will money come from? We request APOC to avoid withdrawing abruptly from Kanungu. Their disengagement, ideally, should be gradual and systematic, thus allowing for reductions in their activities over a stretch of time. In the meanwhile we shall arouse district authorities to step up local contributions in funds and other things. When it has been started, an onchocerciasis program should not take just 3 years; it needs extending to 5 years or more to give us enough time to adjust.

Community members in Kanungu district identifying oncho symptoms

Clar: APOC's agreement, however, was very clear: that after 5 years it will pull out and the district will take over the ownership, administration and financing of the program. This is well known to the district and its people, and their engagement was brought to a close on April 30, 2004. The organization's retreat was therefore something not abrupt. What measures you have put in place, knowing that APOC would pull out, is what we would like to know now.

Bym: When one signs an agreement, you know, s(he) should obey its obligations; but a treaty can be reviewed. So we request the funders (APOC) to reconsider the agreement, bearing in mind what we have been discussing, especially because the cost of the drug is so high for the majority of the unwell. We are thus still hoping that APOC can reverse its departure because we do not yet have much, on the ground, in concrete preparedness for the change.

Clar: Be assured, Mr CAO, that the American Merck Co. Inc., the maker and donor of ivermectin, did agree to continue supplying the drug. Uganda offices of The Carter Center Global 2000, though, have one concern: Would it be easy for Kanungu people to get the drug in the absence of

APOC? Would your district be in position to be accountable to the drug company?

Bym: Purchases of the drug was my main worry; but if the company will continue taking care of that, then the rest will be managed by us. Manpower and other necessary resources can be provided without great difficulty: We have in place a whole essential support system, including community distributors. Subcounties will contribute sums of money they can afford.

Clar: The Carter Center Global 2000 is concerned about community supervisors. These are not government employees. They do not earn a salary, yet they do a lot. They do health education as they supervise distribution of ivermectin, they train drug distributors, and they make sure that accountability is forthcoming. If the district could support these people, then it would probably maintain the assault against onchocerciasis. You people could, furthermore, make simultaneous use of the supervisors in other district programs. So, how are you going to sustain them?

Bym: From Norway we recently got a visitor who introduced me to the concept of "food for work". This is how it is utilized: People set aside their own duties, for a period of time, and do community work. My task now is to interest my councilors in this concept, and show them that this is a priority area. "Food-for-work" laborers need little food for work done by them. Sometime ago I tried the concept in a certain community. We asked them to dig trenches to stop wild game from eating people's crops. After that, we gave them 2 kilograms of sugar each as a token of appreciation.

In this concept you will see the fulfillment of the 3Rs of motivation: recognition, responsibility, and reward. Implementation of the concept, to materially maintain the supervisors, is not a challenge in and of itself because some of our people have tried it before and they will continue to fall back on this strategy.

Fundraising, for the cause of checking onchocerciasis, is the second plan on our table in the post-APOC regime. We also need to discover and put to maximum use all other potentials, at district and sub-county levels, for money generation. Economic, social and other transformation, which we often hear of from Ugandan President Yoweri Museveni and others, does actually result from all such resourcefulness. If drugs are free but we fail to mobilize a community to benefit from them, do you not think that is a scandal? The failure would mean that district administrators would cease to qualify to be leaders in the strict sense. Approaches such as those we have discussed will enable us to have funds to spend, and even more to stash away in reserves for the future.

Byamungu's utterances have many qualities, two of which shall now be our focus. Onchocerciasis, it is admitted, is a persistent problem in Kanungu and some other districts of Uganda. Attempts to restrain or eliminate it, such as in Kanungu and the three districts of Kabarole, Kamwenge and Kyenjojo (which formerly constituted Fort Portal) and mostly with considerable foreign financial, material and other assistance, are acknowledged, appreciated and applauded by him. Another, and no less weighty characteristic is that he is a great believer that the self-help aspect of CDTI can be immensely increased, up from its current low levels. More specifically, he has huge faith that Kanungu folk will sustain CDTI as it will no longer be possible for them to source significant material support from APOC. The interviewer helped him to come to terms with the fact that APOC was gone, and that the clock could not be rewound. If we go by what he has already done in CDTI's interest as well as by his still unimplemented plans for the program, Byamungu cuts the figure of a practical man, a visionary. How Kanungu will run CDTI in big style, without the substantial help of good-doer APOC, does, however, remain to be seen.

* Information expert Julie Gipwola played no small part in my resolve to meet, and extract from, Byamungu material for this text. Deserved recognition goes to her.

[1] It was on 30 April 2004 that APOC finally wound up its formal involvement, of many years, in Kanungu. This was one day after the date, 29 April 2004, of our original appointment to interview Byamungu in Kanungu's capital center – an appointment that did flop.

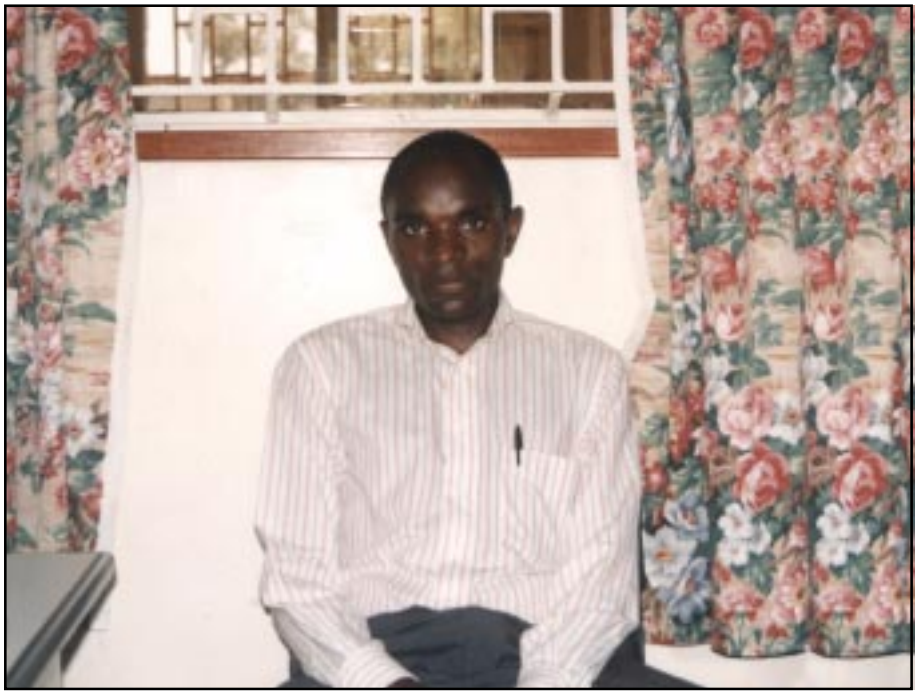
End

A Decade and More of Onchocerciasis Control with Mectizan

Christopher Ruzaza[1]

Introduction

A description of the process, the successes as well as the needs and difficulties of mass treatment programs with Mectizan, this contribution significantly represents the story of the author's personal fieldwork experience of some thirteen years, 1992-2004. For people, to whom this area is of some concern, it is an account that they may wish to hear. The many parts – brief information about the presenter, the era of preliminary surveys and rapid epidemiological mapping of onchocerciasis (REMO), that of the community-based Mectizan distribution program, the introduction of CDTI strategy and its challenges,[2] a discussion and possible way forward as well as some closing remarks – into which the story is broken up, make it readable.



Mr. Ruzaza Christopher at the Carter Center offices

Some Biodata

The author is a holder of a diploma in Medical Entomology and Parasitology. His career in health started in 1989 when he was appointed an Assistant Entomological Technician at the headquarters of Uganda's Vector Control Division, a department under the country's Ministry of Health. He was to fill this position until 1991 when he was elevated and posted to Kabale as a District Vector Control Officer. More promotion was only months away. In 1992 he was assigned the office of District Onchocerciasis Control Coordinator (D.O.C.) – with the two districts of Kabale and Kisoro, in south-west Uganda, as the sphere of his work. The region lies about 450 kilometers from Kampala, Uganda's capital city.

As the Ministry of Health wished to strengthen the control of vector-borne diseases, in the newly created district of Kisoro, the author was later transferred from Kabale to Kisoro where, to this day, he remains D.O.C. and Vector Control Officer. Kisoro District, after recognizing the author's potential in Primary Health Care (PHC) implementation as well as in the control of vectors, did allot the officer additional duties: He was made District Field Coordinator for the malaria control programme; the focal executive of the district's integrated disease surveillance and epidemics control mechanism; the most central promoter of its child deworming and vitamin-A supplementation program; a member of the District Health Management Team (DHMT), a body charged with planning and implementation of the district's health services; and a district trainer in such things as CDTI and the control of vector-borne diseases.

In the area of onchocerciasis control, the author has a certificate of merit from Global 2000 River Blindness Control Program (GRBP, Uganda). Ruzaza has participated in an international workshop in Nigeria's Enugu State. This was in 1997, and the assembly was about the importance of streamlining CDTI field operations.

After recognizing this author's research potential, the African Programme for Onchocerciasis Control (APOC) sponsored him to undertake, under Uganda's Ministry of Health, a 6-month course in research methodology and computer methods in 2002. On this he did very well. As a result of this training, he later served as a member of a 3-person team that carried out, on behalf of WHO and APOC, an external evaluation of the Kabale District CDTI program.

Era of Preliminary Surveys and REMO

There was no clear picture in 1991 of the endemicity in Uganda of onchocerciasis. The last comprehensive surveys had been done in 1975. No clearheaded scientist, however, in the 1990s, would rely on the 1975 data for control of the condition. When I was at college (1996-1998), all that was known, of the existence here of onchocerciasis, was still a rough sketch, By then, though, as illustration from my own work background shows, some vital fieldwork had been done in some of the country's districts where the disease was common.

During 1992, with support from the River Blindness Foundation,[3] we set off to establish and map onchocerciasis endemic villages in Kisoro and Kabale districts. We visited villages in and around Bwindi Impenetrable Forest: all this while we tried to establish the existence of the black flies[4] through local reports or at times by using ourselves as baits for black flies to bite so as to catch them for identification. The next agenda was usually community mobilization, with the communities being invited for meetings, which would be used to educate and sensitize these communities on onchocerciasis. For each village, we finally used to ask for volunteers for rapid determination and assessment of onchocercal prevalency in that particular area.

Community members quite often volunteered when the method used was "rapid nodule palpation" or simply searching of the body for presence of onchocerciasis nodules. However, it was very difficult to convince them to volunteer for skin snipping: this action, for them, was like cutting a big portion of their buttocks and then taking the flesh to the bazungu[5] to create some magic for stopping procreation among the communities. Once these communities stopped giving birth, it was believed, all the villages would be annexed to Bwindi Forest Reserve, a big sanctuary for mountain gorillas that the Bazungu like seeing so much. We would tell them the usefulness of skin snipping, observing that if onchocerciasis were proved to have high incidence in their villages, they would receive Mectizan virtually free of charge. Community members, at times, would refuse volunteering on the first day. In such circumstances we would extend our negotiations for a 2nd day, and even for three days running. On the whole it was indeed tough to convince them to accept to be skin-snipped, but somehow we succeeded and we were able to map all the onchocerciasis endemic villages and to determine the rate of occurrence, in every community, of this condition. We did most of the mapping and the REMO on foot – walking, sometimes, for 3 to 5 hours in the hilly slippery paths. Those days we did not have motorcycles for field trips. Nobody, moreover, at that time, would talk of a vehicle, for this activity, because there was only one rough road, through the forest, which, most times, was not fit for motor traffic. Accommodation itself was not easy to find: So we used to stay with the village leaders in their small houses, which, in most cases, were thatched with grass. We used to carry with us food, clothing, beddings and health equipment from village to village. "Wanderers" of the villages we were. We would spend 2-4 weeks in villages without visiting our families in Kabale town[6] or elsewhere. Life was challenging, but we were committed to make the Mectizan donation program a reality among the communities.

Days of Community-based Drug Distribution

Our new task, after mapping onchocerciasis endemic villages, in Kabale and Kisoro, was to give the Mectizan drug to entire communities, particularly to eligible individuals and families. Health workers were too few for the task; and clinical work, at the few existing facilities, was too much. We hatched the idea of identifying and training community members to assist the health workers specifically chosen to deliver treatment to the communities. For effectiveness and community participation, local leaders were groomed to assist in mobilizing community members as well as in providing them with

health education.

Various improvisations enabled us to weigh and measure the heights of the community members, after which we started mass treatment with the members taking Mectizan on the spot. We kept our records in exercise books; and at the end of each month, we had to produce a treatment report. There were then no pre-designed report formats. My subsequent involvement in designing and developing such formats, which are in use today, was a gratifying experience. Indeed we learnt by doing many things. Later we were to discover that there are activities and processes that one had to pass through to achieve good treatment coverage. As a result, we started planning and implementing such activities as taking a community census, community sensitization and mobilization, training of drug distributors,[7] and others.

Traveling through the hilly terrain, when our transportation improved, was still difficult. One would only reach about 20% of the communities on a motorcycle, for example, on any one day. Supervision of mass treatment and collection of reports from individual CBDs, despite the development, remained hard. Sometimes one had to find a CBD in a garden some 3 km away from his or her home to get a report from him or her.

With much dedication of the key stakeholders, at various stages, from national to village level, treatment was generally successful, none the less. By the time we moved from the community-based approach to the community-directed system in 1996, we were achieving over 80% treatment coverage of the eligible population in over 70% of our communities.

No less interesting are my experiences in Nebbi District, in Uganda's West Nile region, in the country's Northwest. About these, though, I shall talk very briefly. By 1994, some pioneers, myself among them, had successfully established the annual Mectizan distribution program in the three districts of Kabale, Kisoro and Rukungiri, mostly near the Bwindi Impenetrable Forest. Kampala's Country Office of the River Blindness Foundation required our experience to establish similar programs in Nebbi. We packed our bags. We also dismantled some parts of our motorcycles so that these motorbikes could fit in the motor vehicle of the Foundation's Country Office. Ours was a long journey – via Kampala, travelling all the way to and through Karuma falls. Three days, after we set off, we arrived in Nebbi. Many of the roads, which we took, were rough, with potholes, and we were very tired when we reached our destination. We rested for one day as the Nebbi D.O.C. oversaw the reassembling of our motorcycles, which were soon to be packed in the boot of a larger vehicle. REMO had been done by a mobile group with its base in Kampala: Our task was mainly to establish, in Nebbi communities, a Mectizan distribution and mass treatment system. Local languages in the district were a communication barrier for me, and I worked through an interpreter. While such indirect communication was a challenge, at the start, I quickly adjusted, and my work went on smoothly. The Nebbi D.O.C., my Kabale colleague and I worked tirelessly for thirty days including Sundays. When our Kabale team finally left Nebbi to return home, over 50% of its onchocerciasis cases, real or potential, had been treated. These beneficiaries were spread over 100 villages.

Advent of CDTI Strategy and Associated Challenges

We had not anticipated that mass treatment of onchocerciasis-endemic communities would take over 10 years. Therefore there arose the issue of the sustainability of long term Mectizan distribution and treatment program. At a national conference, some scientists presented the results of a multi-country study on the sustainability of Mectizan treatments; and, consequently, we adopted the community-directed strategy. Its initiation did, however, require reasonable funds. APOC's management staff, at one meeting, promised to fund the implementation of the new strategy for five years, after which the government of Uganda and the onchocerciasis endemic districts would sustain the mass treatment program. With the change in strategy, many advocacy meetings were held. Government and district officials, whose support was in high demand, would also be invited to these gatherings. Series of training seminars helped to re-orient health workers as well as community resource persons, including drug distributors and local leaders.

New challenges have risen during the CDTI era – since 1997 to be more specific. The good news is that, for every new challenge

Mr. Ruzaza speaks to men in a community

that crops up, we have either been able to find a solution or we are still on track looking for answers. Challenges, over the years, have included such constraints as these:

- Funding from APOC was not always timely.
- Some health workers, drug distributors[8] and other stakeholders resisted the change to CDTI because the approach does not generously reward them financially.
- Implementation of the new strategy required consistent contact and dialogue with community members, which was tiresome and costly.
- The communities selected many CDDs and supervisors who required intense training, follow up and supervision by the few existing health staff.

In the year 2002, there was an external evaluation of the Kisoro CDTI program. The findings indicated that the program was making reasonable progress towards sustainability. Kisoro District, as we write or read this, has committed part of its annual budget to CDTI implementation, now and later, although this is not sufficient. I am optimistic that, as a district, we shall continue to adjust to meet the latest challenges. As a D.O.C., I feel, indeed, that it is part of my duty to look for solutions to challenges ahead of us.

Discussion and the Future

The Mectizan distribution program is a challenge because onchocerciasis is usually endemic in hard-to-reach areas. As one has described it, it is found "at the end of the road" so to say – a statement borne out by some of my own career experiences, some of which I already narrated.

Efficient transport systems are a must if high treatment coverage is to be maintained. We have this example: Since 1992, as a D.O.C., I have used 3 brand new motorcycles. Old age, while still they were in use, reduced them to scrap. Over 100 times, I fell off the motorcycles; my Kabale colleague died after a motorcycle accident, and, indeed, many other onchocerciasis officers, elsewhere in Uganda, have died or have been crippled as a result of riding on bad roads and terrain.

Onchocerciasis control is quite an expensive venture, both in personnel terms and logistics provision. It requires strong commitment and a lot of sacrifice from a D.O.C. or other CDTI implementers. The spirit of service above self must prevail if we must run the Mectizan distribution programs successfully. Community awareness, through constant health education and information dissemination, should be maintained, using appropriate information education and communication (I.E.C.) strategies.

Conclusion

Onchocerciasis control is a life-threatening task, but we should endeavor to save our people, who are doomed to poor health and poverty by the disease.

America's Mark & Sharp Company has contributed enormously, through its gifts of Mectizan, for the betterment of the world's onchocerciasis endemic communities. Without this drug, these communities would be hopeless, and I personally would have not the kind of field experiences and stories shared here.

Complementary Reading

Ruzaza, Christopher. 12th July 2004. "Problems and Issues to Address to Ensure Sustainability of CDTI in Kisoro District." Unpublished text addressed to the The National Onchocerciasis Task Force (NOTF) Secretariat, Ministry of Health, Uganda. Archives of The Carter Center Global 2000, Bombo Rd., Kampala.

[1] The older edition of this transcript was written and submitted for the Mectizan Donation Program Award. It has been edited to suit the standards of this newsletter.

[2] CDTI is an abridgement of community-directed treatment with ivermectin.

[3] The organization ceased, in the 1990s, to exist in Uganda, but its effort to contain onchocerciasis there was taken over by the Uganda department of The Carter Center Global 2000; thus the 'Global 2000 River Blindness Program (GRBP)' of The Carter Center.

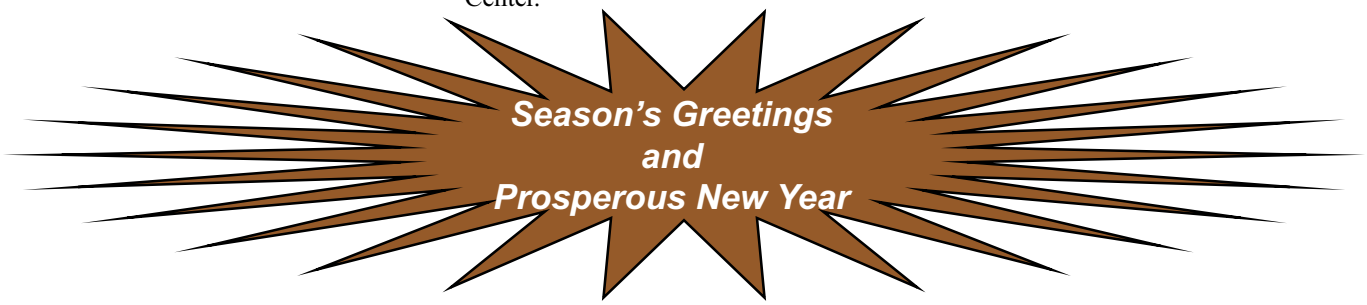
[4] These vectors, also called *simulium* flies, are the cause of onchocerciasis.

[5] Bazungu, or *(a)bajungu*, is the generic name for Europeans and others of that kind.

[6] The capital center of Kabale District.

[7] Who, at that time, were called Community-Based Drug Distributors (CBDs).

[8] Usually known as community-directed distributors (CDDs).



Health Education Objective 2004

District	No. of communities	No. of communities targeted	No. of communities covered	% Achieved
Adjumani	218	218	91	41.7
Apac	9	9	9	100
Gulu	187	187	139	74.3
Kabale	48	24	24	100
Kanungu	105	41	25	61
Kasese	131	0	0	0
Kisoro	32	32	25	78.1
Mbale	580	580	306	52.8
Moyo	189	100	98	98
Nebbi	670	670	572	85.4
Sironko	191	191	50	26.2
Total	**2360**	**2052**	**1339**	**65.3**

Training Objective 2004

District	CDDs			Community Supervisors			H/workers from FLHF		
	Annual Training Objective	Actual Trained	% Trained	Annual Training Objective	Actual Trained	% Trained	Annual Training Objective	Actual Trained	% Trained
Adjumani	2746	2746	100	436	436	100	168	155	92.3
Apac	155	155	100	20	20	100	12	12	100
Gulu	3224	3224	100	179	179	100	70	40	57.1
Kabale	522	522	100	95	95	100	12	11	91.7
Kanungu	1928	1928	100	210	210	100	19	9	47.4
Kasese	779	775	99.5	262	262	100	232	132	56.9
Kisoro	394	394	100	64	64	100	19	9	47.4
Mbale	10043	10043	100	1160	1160	100	132	121	91.6
Moyo	2300	2213	96.2	378	378	100	317	117	36.9
Nebbi	10618	10618	100	1,340	1,340	100	349	112	32.1
Sironko	1522	1522	100	382	217	56.8	35	25	71.4
Total	**34231**	**34140**	**99.7**	**4526**	**4361**	**96.3**	**1365**	**743**	**54.4**

Treatment Updates (Oct - Dec 2004)

Name of District	Total Popn	Popn treated during current month	Popn treated cumulative for 2004	Ultimate Tx Goal (UTG) for 2004	Total Popn TX % for 2004	Popn TX % of UTG 2004	No. of Villages treated during the current month	Active villages cumulative for 2004	Active villages UTG for 2004	Active villages % for UTG for 2004
Adjumani	171,128		143,012	146,563	83.6	97.6		218	218	100
Apac	15,672		12,808	12,818	81.7	99.9		9	9	100
Gulu	204,879		140,114	150,660	68.4	93		187	187	100
Kabale	17,475		13,796	15,235	78.9	90.6		48	48	100
Kanungu	46,448		37,635	38,873	81	96.8		105	105	100
Kasese	95,717		79,505	79,637	83.1	99.8		131	131	100
Kisoro	21,315		16,027	17,861	75.2	89.7		32	32	100
Mbale	179,749		139,982	140,091	77.9	99.9		580	580	100
Moyo	177,788		139,019	140,069	78.2	99.3		189	189	100
Nebbi	283,519		231,950	232,546	81.8	99.7		670	670	100
Sironko	59,789		49,089	49,905	82.1	98.4		191	191	100
TOTAL	1,273,479		**1,002,937**	**1,024,258**	**78.8**	**97.9**		**2,360**	**2,360**	**100**

News Flash

October

6th /10/2004, The Carter Center staff held a one day meeting with all the DOCs from the 11 districts supported by The Carter Center Global 2000 at their national office, Kampala to review the progress of CDTI activities. They shared field experiences, successes and challenges of CDTI and how to overcome them.

12th to 23/10/2004, a group of Entomologists, vector control officers including some DOCs who are experts in skin snips together with medical doctors from Moyo did skin snipping and clinical examination of the disease in Moyo district. Data is still being entered into the computer for analysis.

From 17th to 23rd October 2004 a surveillance team traveled to Kanungu district to monitor CDTI activities through face-to-face interviews with household heads, CDHS, CDHW and community leaders.

The Carter Center staff were in Kasese district from the 24th to 30th October 2004. They witnessed and gave advice where necessary, the district leaders training health sub-district officials, sub county leaders, health workers and community-directed health supervisors (CDHS) in CDTI work and how they could integrate CDT into other health and developmental programs. This was done in a bid to ensure sustainability of CDT activities at these levels.

November

Peace Habomugisha met Dr. Don Hopkins and Mr. Craig at Entebbe Botanical Beach Hotel and discussed important issues concerning onchocerciasis program. In addition, Craig Withers paid a courtesy call to GRBP office in Kampala.

From 15th to 20th November 2004 Peace Habomugisha, Stella Agunyo and a surveillance team traveled to Mbale district to monitor CDTI activities through face-to-face interviews with household heads, CDHS, CDHW and community leaders. Peace also tracked ivermectin form the district down to the health units in both Mbale and Sironko districts.

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