In rural Ugandan Communities the Traditional kinship/ Clan System is vital to the Success and Sustainment of the African Programme for Onchocerciasis Control

Contd. from issue no. 5

THOSE WHERE INDIVIDUAL HOUSEHOLDS FROM MANY DIFFERENT CLANS, OR EVEN FROM DIFFERENT TRIBES, RESIDE IN ONE COMMUNITY (3%)

These communities were usually of the semi-urban type. Since onchocerciasis is primarily a rural disease, experience with applying CDTI in a semi-urban environment is limited. In semi-urban communities one finds a mixture of families from different clans and tribes, displaced from their villages, and no longer necessarily linked to land ownership. Close proximity and lack of known kinship lines leads to mistrust. As Katabarwa et al. (1999b) reported, mobilization of the population in such communities was much more

Focus Group Discussion in Nebbi. This is a good forum to understand the community
difficult and cumbersome than in rural communities (Table 2). In 1998, rural communities achieved a mean coverage of 87.8% for the eligible population whereas the semi-urban communities achieved only 63.3% ($P = 0.049$). Similarly, during 1999, rural communities treated 94.3% of the eligible population whereas the semi-urban communities treated only 71.0% ($P = 0.028$). More health-education sessions and visuals (poster and pamphlets), more video shows, radio jingles and other activities were required to motivate the semi-urban communities. The more complex lifestyles and time-demands on families in the urban environment made it more difficult to bring together a sufficient number of community members to make the meaningful decisions needed to implement a CDTI programme. It was clear that, although neighbourliness and kinship/clan systems were determining factors in implementing satisfactory ivermectin distribution, the degree of these qualities as ‘natural resources’ in semi-urban communities was very varied.

The difficulties in establishing effective CDTI in semi-urban and urban environments are to some extent counteracted by the fact that onchocerciasis usually becomes less endemic as communities enlarge and become more urbanized. As human population densities increase, pollution of local Simulium breeding sites also increases, and there is a consequent reduction in man-fly contact. However, good penetration of semi-urban communities is vital to the success of control programmes for other diseases, such as tuberculosis and lymphatic filariasis, which are transmitted in urban environments and which also require community direction and ownership.

TABLE 2
Mean, community-directed treatment coverages in the meso- or hyper-endemic communities of four Ugandan districts

<table>
<thead>
<tr>
<th>Treatment coverage (%)</th>
<th>Semi-urban communities</th>
<th>Rural communities (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjumani</td>
<td>67 70</td>
<td>98 93</td>
</tr>
<tr>
<td>Kabale</td>
<td>69 67</td>
<td>83 93</td>
</tr>
<tr>
<td>Kisoro</td>
<td>42 59</td>
<td>85 95</td>
</tr>
<tr>
<td>Nebbi</td>
<td>75 88</td>
<td>85 96</td>
</tr>
<tr>
<td>All four</td>
<td>63.3 71.0</td>
<td>87.8 94.3</td>
</tr>
</tbody>
</table>

In rural Ugandan communities where onchocerciasis is endemic, if the annual ivermectin treatments carried out are to achieve their target coverage and become self-sustaining, they need to be based on community-directed distribution. Such distribution, if it is to succeed, must make full use of the existing local kinship/clan system. Similar social systems exist in other African countries and their recruitment into the ivermectin distribution process is likely to be critical for success.

CONCLUSIONS

In rural Ugandan communities where onchocerciasis is endemic, if the annual ivermectin treatments carried out are to achieve their target coverage and become self-sustaining, they need to be based on community-directed distribution. Such distribution, if it is to succeed, must make full use of the existing local kinship/clan system. Similar social systems exist in other African countries and their recruitment into the ivermectin distribution process is likely to be critical for success.

‘Engozi’ is one of the community practices derived from kinship which can enhance CDTI
In Uganda, it becomes more difficult to achieve satisfactory ivermectin distribution coverage in communities that are becoming semi-urbanized, which contain many migrant families, and in which the kinship/clan system is much less strong. This weakening of the kinship/clan system may become an increasing problem for community-directed health programmes aiming to control diseases that, unlike onchocerciasis, thrive in an urban or semi-urban environment.

Most health interventionists concerned with enlisting human behaviour and social structure in the battle against infectious diseases have confined themselves to studies of the ‘knowledge, attitudes and perception’ (KAP) of community members. These KAP studies aim to identify ‘false beliefs’, and then provide a guide to the best approach to replacing them with ‘accurate knowledge’ (Manderson, 1998). The attitude of the interventionist tends to be that of a saviour of the people, whose mission is to rid them of a ‘backward’ culture that promotes disease. Experience in Uganda, on the other hand, shows that these so called ‘backward’ social and cultural systems are important ‘natural resources’, that can and should act as a powerful motivational force for the prevention and control of disease. Experience in Uganda, on the other hand, shows that these so called ‘backward’ social and cultural systems are important ‘natural resources’, that can and should act as a powerful motivational force for the prevention and control of disease (and indeed for the general advancement of the communities).

Increasingly more and more people are migrating from their present rural Ugandan communities towards larger towns or other areas, in search of new opportunities and fortune. In the process they become separated from their kinship groups. At the same time the rural communities are gradually changing and becoming ‘modernised’. The effects of these changes on the kinship system, and whether the bonds of friendship and neighbourliness can replace this, are factors that have yet to be studied. The optimal management of disease-control programmes in these new environments may depend upon the outcome of these future investigations.

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Adjumani district
- 919 community selected CDDs were trained.
- Health education was carried out in all the 119 communities.

Kasese district
- Community self-monitoring was done in 4 communities of Kagando II, Buhungamuyaga II, Kanyatsi I and Kasanga.

Moyo district
- 1,193 CDDs were selected by the community members. 856 were male and 337 were female.
- Health education was carried out in 153 communities.

Nebbi district
- 143 CDDs were trained, 66 of these were women. 240 supervisors were also trained.

**FEBRUARY PLANS**

Adjumani district
- Selection of women CDDs will be carried out and training of CDDs and supervisors will be done.

Gulu district
- Community self-monitoring will be done in 4 communities.

Kasese district
- Continuation with Community self-monitoring in 2 communities.

Kisoro district
- Mass treatment with ivermectin will be carried out.

Moale district
- Training of Supervisors will be done.

Moyo district
- Training of CDDs and Supervisors will be carried out.
- More women CDDs will also be selected.

Nebbi district
- Mass treatment to begin.
- Health education and training of 721 CDDs will be carried out.