



Considering Community Practices in CDTI

In the past four issues, we have reproduced a study on the kinship factor carried out here in Uganda in some of the communities in which onchocerciasis is endemic and in which CDTI is being implemented. This study has brought out a number of issues about the communities which need to be considered in implementing CDTI and other health programmes but also help us to understand why the community behaves the way they do influenced by these factors.

This has helped to emphasise the point that not only has the community in which implementation is being made got to be studied, it has also got to be involved on the basis of their cultural practices and what is acceptable to them in order to get them to participate maximally and for the programme to be effective. This is because as this study shows, the community have a way of doing things which they are used to and are comfortable with. This is also not without reason and it therefore affects the new ideas that are introduced into the community for the benefit of the community but also requiring the involvement of the community.

According to the study, issues such as request for incentives, compliance to treatment, achieving extensive coverage of ivermectin distribution, effective community mobilization and health education are all issues that can be dealt with by considering the ways of the community and what is acceptable to them. The kinship factor and other practices and beliefs of the community are therefore very important factors to consider in the implementation of programmes such as CDTI.

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

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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 Katarbarwa *et al.* (1999b) reported, mobilization of the population in such communities was much more

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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

TABLE 2

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

District	Treatment coverage (%)			
	Semi-urban communities		Rural communities (%)	
	1997	1998	1997	1998
Adjumani	67	70	98	93
Kabale	69	67	83	93
Kisoro	42	59	85	95
Nebbi	75	88	85	96
All four	63.3	71.0	87.8	94.3

(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.

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 (and indeed for the general advancement of the communities).

Increasingly more and more people are migrating from their present rural Ugandan



Community mobilisation can be enhanced by considering important factors to the community such as kinship

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 out-come of these future investigations.

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END

JANUARY NEWS

District	Popn treated during current month	Popn treated cumulative For 2001	Annual Tx Objective (ATO) 2001	Popn Tx % of ATO	No. of villages treated during the current month	High risk villages cumulative for 2001	High risk villages ATO for 2001	At risk villages cumulative for 2001	At risk villages ATO for 2001	At risk villages % for ATO
ADJUMANI			135407				119		119	
APAC			11773				9		9	
GULU			139230				184		184	
KABALE			13735				27		27	
KASESE			73559				125		125	
KISORO	14,817	14,817	16500	89.8	31	100	31	100	31	100
MOYO			129436				177		177	
MBALE			175603				446		446	
NEBBI			213920				670		670	
RUKUNGIRI			36000				102		102	
TOTAL	14,817	14,817	945163	1.64	31	100	1890	1.64	1890	1.64

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.

Mbale 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.

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