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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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In rural Ugandan communities where onchocerciasis is meso- or hyper-endemic, control of the disease is now being carried out using a strategy of community-directed programmes for the annual distribution of ivermectin to all persons eligible to take the drug. For these programmes to achieve their annual target coverage of at least 90% of the population eligible to take ivermectin, and to continue to sustain themselves for 10±15 years or more, even after external donor funding ceases, it has been found essential to replace the initial community-based strategy, imposed from outside, by a community-directed strategy developed by the community members themselves. Furthermore, it is essential for success that full use be made of the traditional social system, which is very strong in all rural communities in Uganda. This system is based on patrilineal kinships and clans, governed by traditional law, and in it women pay an important role. If this system is ignored or by-passed by government health personnel or by the sponsors and promoters of the programme, the communities are likely to fail to reach their targets.

When rural communities increase in size and complexity, following development and the arrival of migrant families, they become semi-urbanized. The kinship/clan system is then weakened, community-directed drug distribution is much more difficult to organize, and coverage targets are not often achieved. This effect is of minor importance in a rural disease, such as onchocerciasis, but is likely to be of greater significance in the control of diseases, such as tuberculosis and lymphatic filariasis, which thrive in urban environments.

Several programmes of mass chemotherapy to control major parasitic and infectious diseases in developing, tropical countries are now being supported by the World Bank and executed by the World Health Organization in partnership with the Ministries of Health in the affected countries. An important feature of this effort is that of public/private partnership: national health services participating with international donor agencies, non-governmental development organizations (NGDO), and major pharmaceutical companies. Most of these programmes are based on the fundamental, final common pathway of community participation and involvement (Katabarwa et al., 1999a).

One of the most successful of these programmes is the use of ivermectin (as Mectizan

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donated by Merck & Co., Inc.) to control onchocerciasis, with its associated skin lesions and `river blindness'. In Uganda this programme started in 1992, as a co-operative venture betwee

to compensate for their loss of time. Where the programme refused such remuneration, the CBD often dropped out of the programme; where the programme did provide remuneration, the CBD tended to become more accountable to the programme sponsors and staff than to their n3

es, the supporting resources, skills fices that are absent at the com- level.

ting CDTI in the ties and Integrating it with unity Agenda

ve of promoting community direc- render the ivermectin-distribution s capable of being sustained by the members at their level. To put ffect successfully demands a sound ding of the cultural factors that the involvement of community n health-care programmes. Account e taken of vital community aspects, he social structures, legal systems, mobilization, and sharing systems.

oncept of community-**directed** treat- h ivermectin has been developed to the vaguer term: community-**based** nt programmes. The latter, in the con- Ugandan onchocerciasis control, were associated with inadequacy or failure. ewer, CDTI strategy involves searching for the correct and appropriate information that can be used to maximize community involvement, both in decision-making and in the assignment of appropriate programme responsibilities to community members for the betterment of their own health. The results of a multi-country study of CDTI for onchocerciasis control (WHO, 1996) and of the work of Katabarwa et al. (1999b) in Uganda have revealed that communities are better able to achieve their target coverage when the community members themselves actually make the decisions as to how the programme should be organized within the community.

The CDTI programme functions in the following way. The district health personnel ®rst [illegible] bene®ts of the programme to the communities by means of participatory health education. That done, the communities are then empowered to make all the local management decisions and carry out the treatment, without external interference. The community members ®rst select their own, community-directed drug distributors (CDD) and treatment centres. Members of the programme staff then tell the selected distributors and the community leaders how to store the ivermectin safely, how to determine dosage, how to manage adverse side reactions, how to keep proper records, and how to prepare reports. The communities are then left to organize their own distribution exercises. In Uganda, a community, once prepared in this way and allowed to plan and implement its own CDTI, almost always achieved and sustained the desired coverage of 90% of the eligible target population (Katabarwa and Mutabazi, 1998).

The approach to the communities targeted for CDTI starts with meetings in the community, to explain the purpose and the strategy of treatment. Success depends on meeting with groups of a signi®cant number or a `criticah::an:

tions and referring individuals suffering from them to local health authorities; and
(7) changing the treatment approach if it is found to be unsuitable after the ®rst round of treatment.

When attempting to integrate a health-care programme into the community, there are certain issues that the organizers of donor-supported and government-sponsored programmes, and the health personnel employed by them, must

TABLE 1

Mean treatment

safety net' is admirably exempli®ed by the traditional, social-support systems, known as the *engozi* in south±western Uganda (Katabarwa, 1999).

It follows that, in rural Uganda, a sound knowledge of the role of kinship is essential if one is to understand the social dynamics of any community and the way in which these will in¯uence the acceptability, management, sustainability and ultimate success or failure of any community-directed, health-care programme. To date, rural health programmes have not taken the kinship issue seriously or even bothered to

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

	Treatment coverage (%)			
	Semi-urban communities		Rural communities (%)	
District	1997	1998	1997	1998