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

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 affected areas, to confirm that they receive ivermectin, to discourage users of the drug from opting out of the treat38.9eo-sgbT80.002 Tc 30.067ents ontrol sccespeoents Twalways from t ofmedical serviceities.
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Looking on is the CAO at a workshop

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, ÒIt will rain tonight,Ó 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.

Clar: APOCÕs 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 organizationÕs 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.

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 ÒFood for workÓ 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. ÒFood-for-workÓ 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 peopleÕs 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.

ByamunguÕs 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 CDTIÕs 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 KanunguÕs capital center —an appointment that did flop.

End

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 802.69 557.32msss

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.

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 Òat the end of the roadÓ 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 commu-

Complementary Reading

Ruzaza, Christopher. 12th July 2004. ÒProblems and Issues to Address to Ensure Sustainability of CDTI in Kisoro District.ÓUnpublished 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 ÔGlobal 2000 River Blindness Program (GRBP)Õ 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

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