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News Highlights

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Involvement and performance of women in community-directed treatment with ivermectin for onchocerciasis control in Rukungiri District, Uganda

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Face-to-face interviews with women in households

In all of the 31 communities studied, face-to-face interviews with women using semi-structured questionnaires were carried out. Lists of mature women (mostly married), one from each household in each community, were made. From these lists, the women from 403 house-

holds were randomly selected (13 from each of the 31 communities), for face-to-face interviews. The numbers of women interviewed were: 143 in Karangara Parish (with 11 communities and 35 kinship zones); 117 in Masya Parish (with nine communities and 33 kinship zones); and 143 in Mukono Parish (with 11 communities and 38 kinship zones). In each community, the first household was selected with the



A community gathering for a meeting

■ Dr. Moses Katarbarwa
■ Peace Habomugisha

■ Dr. R. Ndyomugenyi
■ Harriet Sengendo

■ Mr. A. Onapa
■ Gloria Tumushabe



assistance of a random number table (Kuzma 1992), after which the next 12 households were selected by taking every fifth household in each list. For a study area whose population is homogeneous with about 39000 people, interviews for 245 randomly selected women from households are needed. This is estimated to give a sampling error of $\pm 5\%$ at the 95% confidence level (Salant & Dillman 1994). Prior to random sampling, the questionnaires had been tested in another parish and district where the study was not involved in order to improve their appropriateness, reliability and validity. The interviewers who had a minimum of secondary education and spoke the same language as the people of the study area were trained to interview a sample of randomly selected women. During the interviews, the researchers were always in the area in order to attend to problems which might be faced by the interviewers. Each interviewer was supposed to interview 13 women within 2 days. An extra day was given to those who could not complete the interview within the given period.

The researchers checked each question and where there was a problem, the interviewer provided some explanation or was given more time to go back and verify the responses with the particular respondent.

Each interviewee was questioned on:

1. her attendance at health education sessions;
2. whether she had taken ivermectin during the previous year's distribution;
3. her knowledge of the classes of people not eligible to take ivermectin;



Women calibrate stick to be used for determining dosage

4. her knowledge and beliefs about the effects of ivermectin treatment;
5. her involvement in the CDTI decision-making processes (i.e. the location of treatment centres and the period of treatment) and in the selection of CDHWs; and
6. her attitude towards the comparative performance of female and male ivermectin distributors.

Face-to-face interviews with community-directed health workers

Tested, questionnaires were also administered to all the CDHWs (distributors of ivermectin) in each community according to kinship zones. The main issues dealt with were: (1) the sex of the distributor; (2) the percentage coverage of her or his UTG that was achieved (the UTG for each CDHW being the number of people eligible to take ivermectin among those allotted to the CDHW for

treatment); and (3) the number of days taken by each CDHW to complete the distribution of ivermectin.

Participatory evaluation meetings

During the period when face-to-face interviews of women in randomly selected households were being carried out, participatory evaluation meetings (PEMs) were also taking place in selected communities in the same parishes. Eight PEMs were conducted, three in Masya Parish, three in Karangara Parish and two in Mukono Parish, and both men and women attended the PEMs. The number of people attendance ranged from 38 to 114; and the women attendees outnumbered the men in most meetings. The selected communities had been involved in setting the day, time and place of the PEM (Katararwa et al. 2000a). Each PEM was

guided by a facilitator, assisted by at least four people (i.e. research assistants, health workers and community members), who recorded the community responses. The issues dealt with in the PEM were: (1) knowledge of and attitudes to women's involvement; (2) the involvement of women in the CDTI decision-making process; and (3) socio-cultural structures and processes which enhance or hinder women's involvement in CDTI. The importance of participatory evaluation meetings was to reach a consensus on issues which could not easily be included in individual face-to-face interviews.

Participant observation

The researchers also employed the method of participant observation: time was spent visiting, interacting with and observing what was happening among community members (Haviland 1997), especially in Masya and Karangara parishes. Observations were made regarding how communities selected their CDHW, how the CDHWs organised the distribution exercise, and how they were involved in treating community members and kept records. The researchers visited the study area regularly at every stage of the study and during the implementation of community-directed treatment with ivermectin activities. Participant observation was done from June 2000 to March 2001. During visits in the communities, the researchers interacted with community members (both women and men), female and male CDHWs, community leaders, as well as health workers. The researchers lis-

tened, observed and asked questions in order to find out the following: (1) the selection of female CDHWs; (2) their performance as viewed by other community members; (3) the problems which they faced; (4) how the CDHW or communities had organised the ivermectin distribution exercise (e.g. how they allocated the households to treat, and the proximity of the allocated households to the female or male CDHW homesteads); (5) record keeping; and (6) the management of rare side-effects. Participant observation helped in understanding issues which were deliberately hidden from the researchers during face-to-face interviews and PEMs. Nevertheless, these observations could provide explanations on why some CDHWs succeeded while others failed or faced many problems during the course of carrying out CDTI activities.

Data analysis

The women interviewees in the three parishes were divided into: (1) those who had been treated with ivermectin during the previous year and those who had not; and (2) those who had attended health-education sessions and those who had not. Using the chi-square test for statistical significance (with Yates' correction, where appropriate), the differences in numbers of women in each group answering satisfactorily 'Yes' or 'No' to questions on the following topics were compared as regards: (1) their knowledge of the classes of people who are not eligible to take treatment with ivermectin; (2) their knowledge and beliefs about the effects of ivermectin; (3) their involvement in CDTI decision-making in the selection of CDHWs; (4) their knowledge of women's involvement in mobilizing community members (5) their views or attitudes on the relative

performances of female and male CDHWs. During analysis, as regards attitudes, strongly agree and agree meant 'yes' while strongly disagree and disagree meant 'no'. For easy analysis, quantitative data was checked, coded, entered into the computer and analysed using the EPI-INFO computer program (Melissa & Miner 1997).

Results

Table 1 shows the numbers and percentages of women interviewees who had been treated with ivermectin in the previous year, and the numbers and percentages who had attended health education sessions, for each of the three parishes in the study. (Explicit P-values are given where possible to allow the comparison against a Bonferroni-corrected significance level of $p = 0.05/3$, as I here are three pairwise comparisons for each item.)

The percentages of interviewees who had been treated with ivermectin were appreciably higher in Masya Parish and Karangara Parish than in Mukono Parish. There was no statistically significant difference between Masya and Karangara parishes, but the difference between each of these and, Mukono Parish was highly significant. In Masya Parish where health education and active involvement of women in CDTI activities was the strategy, all of the women interviewees had attended health education sessions. In Karangara Parish, where the importance of having women as in CDTI and selecting them as ivermectin distributors

was raised, almost 92% of interviewees had attended the Sessions. In Mukono Parish, where the issues were not raised, only 70% of interviewees had attended sessions. The differences between all pairs of parishes were statistically significant.

wards treatment of the bedridden (only 56% of women from Mukono Parish agreed or strongly agreed that the bedridden should not be treated).

Women from Masya Parish were generally more knowledgeable on the benefits of taking ivermectin than

Parish “were not significant (allowing for a Bonferroni correction to the significance level), but differences between each of these parishes and Mukono Parish were highly significant.

Table 1 Treatment with ivermectin and attendance at health education sessions by parish

Variable	(1) Masya			(2) Karangara			(3) Mukono			Level of significance		
	Yes	No	Total	Yes	No	Total	Yes	No	Total	1&2	1&3	2&3
Treatment with during previous year	108(93.1%)	8(6.9%)	116	127(90.1%)	14(9.9%)	141	101(71.6%)	40(28.4%)	141	NS	P<0.001	P<0.001
Attended health education sessions previous year	116(100%)	0	116	131(91.6%)	12(8.4%)	143	100(70.4%)	42(29.6%)	142	P<0.004	P<0.001	P<0.001

NS, not significant

Table 2 shows the responses to questions, broken down again by parish. For almost all questions, the percentage of positive responses was highest for Masya Parish and lowest for Mukono Parish.

The women interviewees from Masya Parish were more knowledgeable than women from Karangara Parish or Mukono Parish on the groups who were not supposed to be treated. Differences between Masya Parish and Karangara Parish were statistically significant apart from responses towards treatment of the bed ridden (89% of women from Masya Parish and 82% of women from Karangara Parish agreed or strongly agreed that the bedridden should not be treated). Differences between Masya Parish and Mukono Parish were significant for all three questions. Women from Karangara Parish and Mukono Parish only differed significantly in their response to-

women from Karangara Parish and Mukono Parish. In terms of making one feel good, preventing blindness and de-worming, differences between Masya Parish and each of the other two parishes were highly significant, while Karangara Parish and Mukono Parish only differed significantly in attitudes towards the prevention of blindness. The only question in which women from Masya Parish showed fewer positive responses than women from the other parishes concerned the stopping of itchiness: only 22% of women from Masya Parish agreed or strongly agreed with the statement, compared with 39% from Karangara Parish and 29% from Mukono Parish. However, only the difference between Masya Parish and Karangara Parish was statistically significant.

The participation of women in decision-making in community-directed treatment with ivermectin was highest in Masya Parish, and lowest in Mukono Parish. Differences between Masya Parish and Karangara

Women from Masya Parish were more aware of women’s involvement in mobilisation of other community members than those from Karangara Parish, who were more aware in turn than those from Mukono Parish. The difference between each pair of parishes was statistically significant.

Women from Masya Parish had a better attitude towards female CDHWs than those from the other parishes. Differences between Masya Parish and each of Karangara Parish and Mukono Parish were highly significant, whereas there were no significant differences between Karangara Parish and Mukono Parish.

To be continued in the next issue

Recently Peace Habomugisha was in Moyo to do some field work. While there she talked to Mrs. Azireo Maritina who is the LC III Chairperson Moyo district. Here is the interview

Qn: What inspired you to stand for chairperson, especially LC III, considering there are very few women councillors?

Ans: I had been involved in community work for a long time and I discovered that a number of women although not educated managed leadership posts in groups they had initiated in their local villages. I looked at these women, many were not very educated, so I thought I too could be a leader. Because at least I had the education advantage.

Secondly, most women in the communities where I had worked, were always occupied with household chores. These women had no time to even attend meetings and workshops which sometimes should have been to their benefit. Some were even held back by their spouses. Then I realised that women in our community or rather village were not involved in any decision making process. So I thought my joining politics would give me an opportunity to help other women. I thought we needed an advocate, so I decided to become the advocate for my fellow women.

Qn: So you say you are an advocate for your community, what measures have you put in place to make sure that the above concerns are addressed?

Ans: In a way I have become a source of inspiration to these women. They now have the confidence to and actually attend most meetings. Even participate. Actually most of my campaign managers in the

Qn: I thought your main target was women, but you plan to include men in your sensitisation campaign why is it so?

Ans: Women do not live in isolation, we live in an interdependent community. So in order to make a change in any society one needs to intergrate and address concerned parties which in this case includes the men.



Mrs. Azireo Maritino standing left, shaking hands with Peace Habomugisha

race to the LC III chairperson were women.

I am planning to carry out more sensitisation workshops for both men and women in my area. And my major focus is the importance of women's involvement in decision-making at various levels. And if the funds are available I intend to expose the women to others through exchange visits. I think this will also inspired and encourage them.

Qn: You said you were initially involved in community work what exactly were you doing?

Ans: I worked as a field extension worker in charge of Ciforo sub-county. I also worked with the Lutheran Federation an NGDO that was dealing with the settling of refugees from Sudan. I was mainly helping women with agricultural matters. I also did some work with the

village oriented Development Programme an NGDO supported by the Austrian government. Although by 2000 I was only working as a field extension agricultural worker in charge of Moyo sub-county.

Qn: So when did you quit agriculture to join politics?

Ans: In 2001 I quit agriculture but am still involved in community work through politics.

Qn: Has your community been supportive? How do they look at you as a leader; both the men and women?

Ans: They have been supportive. They even encouraged me to contest for this post. Yes

they have given me both physical and moral support.

Qn: How about your family? Tell us about them. Have they been supportive?

Ans: I was married but I am separated from my husband. I have four children, all in school. And they are very supportive and loving.

Qn: Have you been involved in onchocerciasis work?

Ans: No. Except I have taken ivermectin and I did not know much about the programme until Dr. Katarwa visited us. He explained to us in details as a council about the programme.

Qn: Why is it that you haven't been involved in onchocerciasis yet you were a community worker?

Ans: I was involved more in agriculture work than health. But at least I know my ivermectin distributors who come around every year to give me the medicine.

Qn: So what do you think the community should do to support the onchocerciasis programme?

Ans: The community health supervisors should give us their work plan so that we can integrate their activities in the sub-county budget and work plan. We shall open a file at our sub-county and a desk for the health supervisors will be created in the health sector provision.

Editor's Note

Mrs. Azireo promised to put a personal initiative into supporting CDTI activities. Mrs. Azireo's commitment is a reflection of what other relevant officials in other sub-counties located in onchocerciasis endemic areas have done in order to sustain CDTI.

End

Treatment Updates

District	Popn treated during current month	Popn treated cumulative for 2002	Ultimate Treatment Goal (UTG) 2002	Popn TX % of UTG	No. of villages tx during the current month	High risk villages cumulative for 2002	High risk villages UTG for 2002	High risk villages % for UTG for 2002	At risk villages cumulative for 2002	At risk villages cumulative for 2002	At risk villages UTG for 2002
ADJUMANI		134,411	139,500	96.4		218	218	100	218	218	100
APAC		12,200	12,200	100		9	9	100	9	9	100
GULU	109,835	137,529	143,400	96	184	184	184	100	184	184	100
KABALE		13,542	14,500	93.4		48	48	100	48	48	100
KANUNGU		36,280	37,000	98.1		102	102	100	102	102	100
KASESE		75,800	75,800	100		129	129	100	129	129	100
KISORO		15,906	17,000	93.6		31	31	100	31	31	100
MBALE		133,340	133,340	100		580	580	100	580	580	100
MOYO		131,896	133,320	98.9		189	189	100	189	189	100
SIRONKO		42,926	47,500	90.4		191	191	100	191	191	100
NEBBI		217,788	221,340	98.4		670	670	100	670	670	100
TOTAL	109,835	951,618	974,900	97.6	184	2,351	2,351	1100	2,351	2,351	100



Rebecca Dau (standing third from left, front row) and other Lions pose for a group photo with Kanungu district drama group members

News Highlights

u Rebecca Dau and her team from Lions Clubs International Foundation visited Uganda from 6th - 11th Dec, 2002. During her visit, she reviewed RBP-Uganda and visited Kabale and Kanungu districts. They were accompanied by the local Lions including Lion Dr. Moses Katarwa.

u The surveillance team monitored CDTI activities in Adjumani, Mbale, Kasese, Kisoro and Nebbi districts. They held face to face interviews with household heads, community directed health supervisors, community leaders and community directed health workers. They also checked community registers in a number of communities which had been randomly selected in

order to validate treatment records presented by the districts.

u Health education was carried out during the month of October in Adjumani, Apac, Kabale, Kanungu, Kisoro, Moyo and Nebbi districts. In Kisoro district health education and training was facilitated by health workers at the sub-counties with the assistance of community leaders. And in Kabale it was done by the District Onchocerciasis Coordinator and two Lion members.

u Dr. Moses Katarwa and Peace Habomugisha visited Adjumani and Moyo districts. They held advocacy meetings with the district and sub-county leaders on their support for community directed health supervisors. The leaders supported the idea and pledged to sign letters committing that the sub-counties will begin supporting their CDHWs with effect from 2002/03 financial year.



Rebecca Dau at a dinner party with fellow Lions at Grand Imperial Hotel, Kampala

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