DISEASE PRESENTS WITH IRREGULAR FEVER, WEIGHT LOSS, ANAEMIA

BLACK FEVER: THE SILENT KILLER OF VULNERABLE UGANDANS

By John Musenze

When 12-year-old Agnes Lopeta arrived at Amudat Hospital, she was too weak to stand, let alone walk. Nurses gently lifted her from her mother's back and placed her on a bed as her half-open eyes struggled to follow the ceiling light.

For weeks, her tiny body had been overtaken by persistent fever, weight loss and a swollen stomach that terrified her family members.

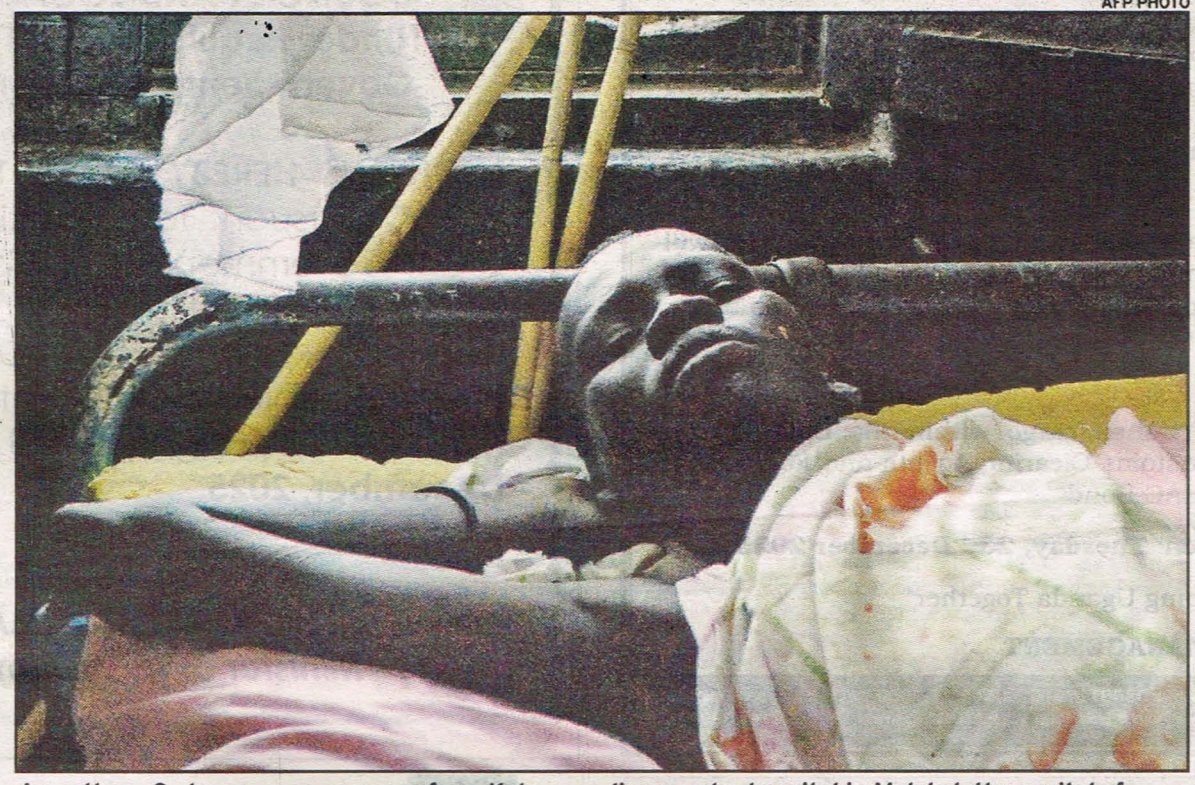
Back in her home village of Lopedot in Pokot county, Amudat district, some community members believed that Lopeta had been bewitched much as they confessed to have seen similar cases before.

The symptoms of Lopeta's illness are linked to a disease locally termed 'Termes', but medically called visceral Leishmaniasis, commonly known as Kala-azar or black fever.

Lopeta's mother, Faith Amany, only knew one thing; she was losing her daughter.

"Twice they said it was malaria. She stopped eating, she could not walk and her stomach kept swelling. People said maybe it was witchcraft. I didn't know what to believe because I have seen some people with the same way before," she told *New Vision*.

Eight days into treatment, Lopeta slowly started regaining strength, but has to stay for two more weeks to complete the full medication.



AFP PHOTO

A southern Sudanese man recovers from Kala-azar disease at a hospital in Malakal, the capital of Upper Nile state, on November 6, 2009. Kala-azar has become a silent predator in parts of Karamoja

ABOUT DISEASE, PREVALENCE

Kala-azar has become a silent predator in parts of Karamoja; fatal in over 95% of untreated cases. The disease is primarily caused by the protozoan parasite Leishmania donovani, which is transmitted to humans through the bite of infected female phlebotomine sandflies.

The disease presents with irregular fever, weight loss, anaemia and swelling of the spleen and liver. In hard-to-reach districts like Amudat, it is often mistaken for malaria, typhoid or witchcraft until it is sometimes too late to save the patients.

Uganda has pledged to eliminate Kala-azar as a public health problem by 2030 under the World Health Organisation (WHO) guidelines, aiming at detecting at least 85% of the cases and treat 95% of them.

But while national targets focus on numbers and timelines, frontline health workers in Karamoja describe a reality far removed from the conference halls in Kampala.

Dr Loyce Faith Nangiro, a clinician at Amudat General Hospital, has witnessed the disease's cruelty for years. She says the disease is primarily confined to the Karamoja sub-region, with the majority of the cases confined to Amudat and Moroto districts.

"Most of the cases originate from Kenya, and most patients we see are children under 15. By the time they reach us, they are severely malnourished, weak and in pain. Families first treat malaria, then typhoid, then try herbs, and by the time they arrive here, the disease has already advanced," she says.

Nangiro says the case fatality stands at 5% of all cases reported, adding that the overall burden of Neglected Tropical Diseases (NTDs) like Kala-azar, river blindness and trachoma, remains high with approximately 87% of the population in hard-to-reach areas at risk of contracting at least one.

Treatment is not only urgent, but also intense. Patients require painful daily injections for 17 to 21 days. The second-line treatment is reserved for complicated cases and is administered intravenously over 10 days, Nangiro says.

"These drugs are strong and very painful. Children cry through the injections, but it is the only way to save them," the doctor says, adding that the most significant challenge in combating Kala-azar is lack of data, with many cases going unreported.

She says this results into deaths, especially of children from home, suggesting that the actual mortality could be higher than reported.

Amudat records between 150 and 300 Kala-azar cases annually, with about 30 to 50 cases recorded each month.

Children are most affected and they remain hospitalised for up to three weeks, a difficult period for carers in a region already struggling with poverty, hunger and long distances to health facilities.

When Kala-azar strikes, families lose weeks of income while attending to the sick, and children drop out of school. The situation is worsened by malnutrition among young patients.

Compounding these challenges is the seasonal nature of the disease. During the rainy season, when malaria cases peak, Kala-azar symptoms are often confused with those of malaria, delaying proper diagnosis. This misdiagnosis in remote health centres is fuelled by the limited laboratory capacity.

To counter this, Amudat relies on community surveillance teams to search for cases across the district. But the semi-nomadic lifestyle of many households makes follow-ups difficult.

"Being a mobile community, we fail to find the patients to do follow-ups. We also lack psychosocial support services that these families desperately need," Nangiro says.

"While many cases progress over several months to two years, acute forms can be fatal in as little as 3-4 months, particularly in young children," she notes.

These gaps widened further after US-supported health programmes faced funding cuts, which would initially enable the surveillance of NTDs, help in carrying out diagnostics and community outreaches.

Nangiro says they are currently depending on 'The End Fund' programmes to combat NTDs through integrated treatment programmes that include distributing drugs, training health workers and providing education. The End Fund is a global philanthropic organisation dedicated to combating NTDs.

Health minister Dr Jane Ruth Aceng told Parliament in March this year that Uganda lost sh604b due to US donor-fund reductions, including sh780m that was specifically for NTDs. While treatment continues, frontline districts have felt the strain through shortages of test kits, interrupted outreach and delayed reporting.

Dr Patrick Sagaki, the superintendent of Amudat Hospital, who has studied and treated Kala-azar since 2007, describes it as a disease rooted in inequality.

"It affects only the poorest of the poor. Most of our patients are Pokot herders and other pastoralists from northern Kenya. They live in remote places with no roads, no public transport and very limited health services. Identifying cases requires active searches, which is extremely costly. Without partners, we would never reach most of them." he say.s.

Sagaki says the tiny insects that transmit the parasite thrive in the dry, arid conditions that stretch across Karamoja and northern Kenya.

This harsh environment, combined with poor housing, close proximity between humans and animals, long distances to health facilities and low disease awareness, create the perfect breeding ground for Kala-azar.

Dr Daniel Kyabayinze, the health ministry's director of public health, under whose docket the NTDs' programme falls, says the country remains committed to the elimination of Kala-azar but acknowledges persistent challenges.

"Uganda has made progress in training health workers, expanding treatment and improving diagnostics. But Kala-azar is concentrated in hard-to-reach regions with limited infrastructure. When external funding reduced, these areas felt it first, but when we integrated health services, care of all NTDs is now accessible to all patients and we are now back on track to triple elimination," he states.

Kyabayinze, a seasoned epidemiologist, notes that achieving the elimination target of Kala-azar by 2030 will require stronger domestic financing, vector control interventions, increased community awareness and prioritisation of hotspot districts like Amudat.

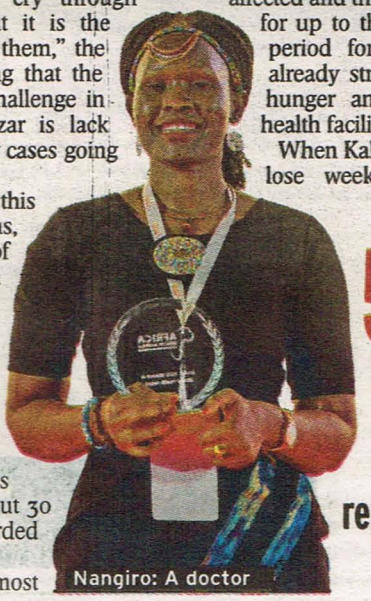
"Kala-azar is a silent disease. When we don't look for it, we miss it. And when we miss it, we lose lives," he warns.

KALA-AZAR STATISTICS

The World Health Organisation reports that East Africa now carries the highest number of Kala-azar cases globally. In Uganda, Amudat has the highest prevalence rate, with an average of 139 cases per 100,000 people.

A 2025 study in Moroto district found a 5.21% prevalence rate, with Matheniko county having the highest infection rate of 6.9%.

Poverty, malnutrition, HIV co-infection and population movements all increase the disease risk. Timely diagnosis and effective treatment remain the only means of preventing death and disability caused by Kala-azar, according to experts.



Nangiro: A doctor

5%

The percentage of fatalities of all cases reported, Nangiro says.