



## Trachoma Control Program Conducts First Annual Program Review

The Carter Center Trachoma Control Program held its first annual program review at The Carter Center in Atlanta Feb. 10-11. The review focused on the Trachoma Control Programs of Ghana, Mali, and Niger. The format for the meeting, based on the successful Global 2000 River Blindness Program (GRBP) and Guinea Worm Eradication Program reviews, created a forum for national program coordinators to present and discuss their work with their peers and promote sharing and standardization of information.

The objectives of the Trachoma Control Program Review were to assess the status of each national program,

identify challenges to national trachoma control programs and discuss possible solutions. National program coordinators and their partners discussed impediments and problems in program implementation and strategies for the coming year.

As in the GRBP program reviews, the *continued on Page 2*



Charles MacKenzie

An ophthalmologist from Sudan's Ministry of Health examines a child's eyes for trachoma in southern Sudan. See related story on Page 6.

## More Than 6 Million Assisted Treatments Reported for 1999 at River Blindness Program Review

The Carter Center hosted its Global 2000 River Blindness Program (GRBP) Fourth Annual Program Review in Atlanta, Feb. 7-9. The review covered the GRBP's activities during 1999.

Drs. Donald Hopkins, associate executive director, The Carter Center, and Frank Richards, technical director, GRBP, co-chaired the review. Attending were GRBP country representatives Dr. Albert Eyamba, Cameroon; Teshome Gebre, Ethiopia; Moses Katarawa, Uganda; Dr. Emmanuel Miri, Nigeria; Dr. Mauricio Sauerbrey, Onchocerciasis Elimination Program for the Americas (OEPA); Elvin

Hilyer, Sudan/Khartoum, Bruce Ross, Sudan/Nairobi; Professor Mamoun Homeida, chairman, National Onchocerciasis Task Force, Sudan; Irene Goepp, program manager, HealthNet International, Sudan; and Global 2000 Atlanta headquarters staff. Special guests included Peter Lynch, Lions Clubs International Foundation (LCIF); Rebecca Daou Teel, LCIF; Dr. Brian Bagnall, director of Lymphatic Filariasis, SmithKline Beecham; Dr. Dan Colley, director, Division of Parasitic Diseases; Centers for Disease Control and Prevention (CDC); Dr.

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## Trachoma Control Program

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current status of each national program was presented, followed by a discussion. Each presentation included epidemiological and sociological data, program interventions being undertaken, plans for monitoring and evaluation of the program, program partnerships with other ministries and international development organizations, successes, constraints, and challenges to the program, and the goals and objectives for this year.

The presenters included three national trachoma control program coordinators, Drs. Maria Hagen, Doulaye Sacko and Abdou Amza, representing the ministries of health of Ghana, Mali, and Niger, respectively. Dr. Mamadou Kane, director general of public health of Mali also attended. Professor Mamoun Homeida represented Sudan's program.

In addition, Carter Center resident technical advisors and country representatives from Ethiopia, Mali, Niger, Nigeria, and Sudan participated in the meeting. Representatives of the Hilton Foundation, Lions Clubs International, Pfizer Inc., the International Trachoma Initiative, the World Health Organization, Helen Keller Worldwide, the Centers for Disease Control and Prevention, Michigan State University, and Emory University also participated.

At the end of the meeting, recommendations were suggested for each national program to improve trachoma control efforts and strengthen the "F" and "E" components of the SAFE Strategy — Face and hand washing to prevent transmission of trachoma and Environmental changes to improve hygiene and sanitation. This meeting also included a session on program monitoring and evaluation indicators. A second annual program review will be held in Atlanta in early 2001.★

## Fourth Annual Review

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Steve Blount, director of Global Health, CDC; Ross Cox, deputy director of Global Health, CDC; Dr. Danny Haddad, Helen Keller Worldwide; and representatives from the Mectizan® Donation Program at the Task Force for Child Survival and Development, Drs. Stefanie Meredith, Bruce Dull, Charles Mackenzie and Mary Alleman, and other observers.

The program review is modeled after similar ones that The Carter Center's Global 2000 program and the CDC developed for Guinea Worm Eradication Programs.

The review's objectives were to:

- Assess the status of each program
- Identify impediments and problems in program implementation and potential solutions
- Promote sharing and standardization of information.

Each GRBP-assisted program reported on the number of assisted Mectizan® treatments provided, training, research, and development activities, and Mectizan supply issues.

The Africa programs reported on their experiences in partnership with the African Programme for Onchocerciasis Control (APOC), which is executed by the World Health Organization (WHO) and funded through a trust fund at the World Bank. APOC, a \$124 million, 12-year program launched in 1995, aims to establish "community-directed" river blindness treatment programs in African countries by 2007. The Nigerian country representative also reported on the pilot initiatives for lymphatic filariasis elimination and schistosomiasis control.

At the meeting it was concluded that 6,631,242 people were treated (96 percent of the 1999 annual treatment objective) in GRBP-assisted programs in

1999, representing an 18 percent increase in treatments over 1998. As in previous years, 69 percent of all GRBP-assisted treatments were in Nigeria. Of the treatments in 1999, 4,758,002 (72 percent) were accomplished in partnership with the LCIF Program in Nigeria, Cameroon, and Sudan.

Since launching in 1996, GRBP has assisted in providing more than 21.2 million Mectizan® treatment encounters. The GRBP annual treatment objective for 2000 is about 7.4 million treatments, an 11 percent increase over 1999 treatments.

Priorities for GRBP in 2000 include:

- Maximizing treatment and health education efforts to reach annual treatment objectives and ultimate treatment goals (*see "GRBP Moves Closer to Full Coverage"*)
- Monthly reporting of Mectizan® treatments
- Documenting the interruption of transmission in the Americas
- Adapting Mectizan® distribution and health education methods to lymphatic filariasis and schistosomiasis. ★

## GRBP Treatments Down in First Trimester

From January to April this year, The Carter Center's Global 2000 River Blindness Program assisted in providing 731,666 treatments with Mectizan®, which is 10 percent of the annual treatment objective (ATO). The first trimester report of assisted treatments was the lowest ever for GRBP (Figure 1),

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## GRBP Treatments

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representing a reduction in treatments by 50 percent compared to the first trimester of 1999. The lag in overall GRBP-assisted treatments was due to different problems in Cameroon, Nigeria, and Sudan.

In Nigeria, the first trimester assisted treatments were down by 60 percent (Figure 1). This was partly because of a request from the African Programme for Onchocerciasis Control (APOC) and the Nigeria National Onchocerciasis Task Force (NOTF) for a complete census exercise (divorced from treatment activities) in the first quarter.

The decrease also could be attributed to urging by APOC/NOTF that peripheral training sessions include no more than 20 Community Directed Distributors (CDDs) per training session. GRBP programs must train or retrain more than 7,000 CDDs per year, meaning more than 350 training sessions would be required.

Both have put enormous stresses on logistical support in the nine GRBP assisted states in Nigeria: Abia, Anambra, Delta, Ebonyi, Edo, Enugu, Imo, Nasarawa, and Plateau States. However, GRBP Assistant Director Dr. Kenneth Korve reported that with 344,347 assisted treatments reported in May, the program may have recovered.

Cameroon provided no treatments during the first trimester due to the need to conduct in-depth training of district teams, nurses, and community distributors to recognize and manage the adverse reactions that have been observed in *Loa loa* endemic areas in central Cameroon. In May, however, the Ministry of Public Health in partnership with GRBP and APOC,

provided more than 71,398 treatments in North Province. No treatments have yet been reported by the GRBP-assisted program in West Province.

In Sudan, treatment activities were halted as negotiations took place regarding the terms of a newly required memorandum of understanding (MOU) between the Sudan Relief and Rehabilitation Association, which is the humanitarian arm of the Sudan Peoples Liberation

Army, and nongovernmental development organizations (NGDOs) working in south Sudan. The MOU has been signed by International Medical Corps (IMC) and World Vision (WVI), two of three NGDOs receiving support from The Carter Center/Lions Clubs to carry out treatment activities in south Sudan in GRBP-assisted areas. Reports from government-held areas have not been received.

Treatment activities in the Americas (the Onchocerciasis Elimination Program of the Americas-OEPA) and in APOC/GRBP-supported areas of Uganda, appear to be on track compared to previous years.

Overall treatments reported so far by GRBP-assisted programs in 2000 is 2,255,080 (Table 1). ★

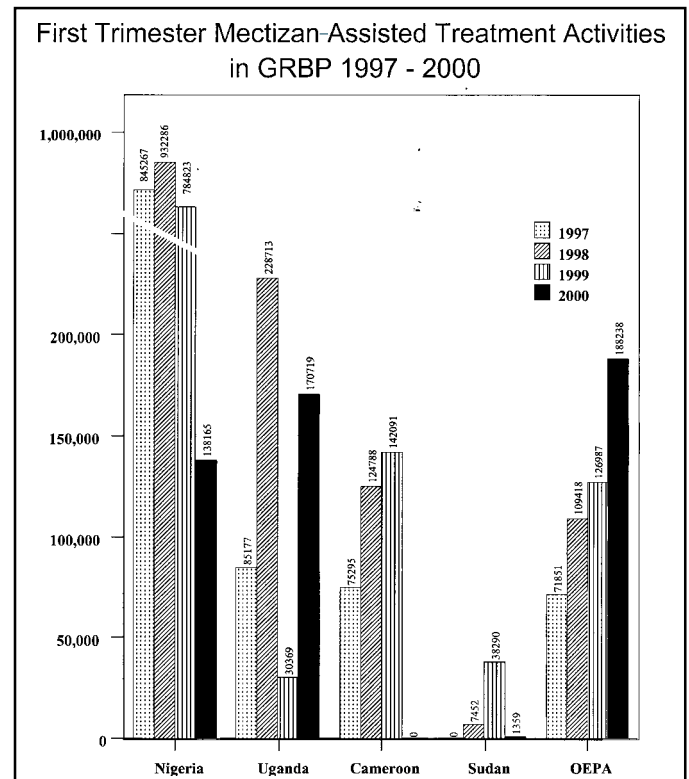


Fig. 1

## GRBP Sets 'Ultimate Treatment Goals'

A particular focus on the Review of 1999 was to set year 2000 Annual Treatment Objectives (ATOs) and establish the Ultimate Treatment Goals (UTGs) for each program. The ATOs for treatment during the year are based on the request for tablets from Merck and Co. Inc. for treatments. They also are based on the program's capacity to reach the at-risk communities that need mass treatment. In contrast, the UTG is defined as the sum of the known or estimated eligible populations living in all at-risk villages in a GRBP-assisted area. The eligible at-risk population are all persons living in at-risk villages who can receive ivermectin, e.g., who are over five years of age and in good health, excluding pregnant women and

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## GRBP Sets Goals

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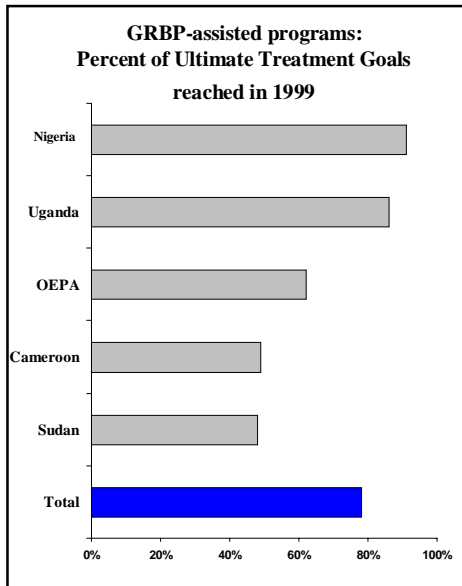


Fig. 2

women in early lactation.

Since the UTG is that number of persons estimated to ultimately require Mectizan® treatment in a GRBP-assisted area, the point when the program can demonstrate that it has treated the UTG has been defined in our program as “full coverage.” GRBP program progress is judged not only by the ability of the

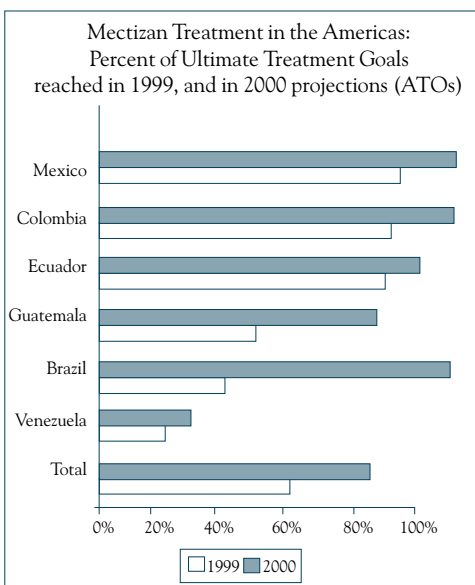


Fig. 3

program to meet its annual treatment projections, but also to increase those objectives over a reasonable time period to fully reach the ultimate treatment goal.

In 1999, GRBP programs reached 78 percent of its UTG (Figure 2), led by the Nigerian program at 92 percent and Uganda at 86 percent. Programs in need of additional growth included: OEPA, which is 62 percent towards its UTG; Cameroon, 49 percent; and Sudan, 48 percent.

In the Americas, completion of the progress in epidemiological characterization of northern Venezuela has lowered

the estimates of the UTG to less than 500,000. Colombia, Mexico, and Ecuador are already operating at near full coverage (Figure 3) whereas, Brazil, Guatemala, and Venezuela are operating at relatively low coverage rates (42 percent, 48 percent, and 24 percent respectively).

However, the 2000 ATOs proposed by those national programs call for dramatic increases in treatment (Figure 3, shaded bars). Increasing treatments in Brazil, Guatemala, and Venezuela represent major challenges to the OEPA goal of eliminating all new onchocerciasis morbidity and transmission in the region. ★

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## Ghana Conducts Knowledge, Attitudes, and Practices Study in Upper West Region

The Ministry of Health of Ghana, with support from The Carter Center, completed a knowledge, attitudes, and practices (KAP) survey of communities at risk for blinding trachoma in Ghana's Upper West Region (UWR) in April 2000.

The study included eight focus group discussions involving 75 participants, followed by a KAP survey of 400 people.

Data collection in 16 communities, which was conducted in all five districts of the UWR in November and December 1999, included a representative sample of the three major ethnic groups of the region and was done in the three local languages. Under the direction of regional director of Health

Services, Dr. Francis X. Kofi Banka, health staff from the UWR worked with the ministry's Health Research and Health Education Units. The Carter Center assisted in the collection and analysis of data.

The study found that:

- Eye problems are an important health concern in the UWR, ranked third after malaria and diarrheal disease.
- Community members are aware of both active trachoma and trichiasis, but have misconceptions about their cause, spread, and prevention.
- Community members are not aware of surgery as an option to prevent blindness caused by trichiasis.
- Topical ophthalmic antibiotics are not accessible because of high cost or unavailability in the study

communities.

■ Almost all of the respondents said it is important to have a clean face. Most respondents reported washing their own faces at least twice daily, however, children's faces were reported to be washed less frequently and were observed to be dirty.

■ Community members perceive flies to be a problem, both as a nuisance and cause of disease. A clean environment is thought to be a good way to decrease flies.

■ The vast majority of respondents do not have access to toilets in their communities.

■ Fifteen of the 16 communities in the survey had at least one functional hand-pump well.

A workshop to develop health education messages and training materials for trachoma control in the UWR, focusing on face and hand washing and environmental changes to improve hygiene and sanitation, is being planned.★

Onchocerciasis: 2000 Mectizan treatment figures for Global 2000 River Blindness Program (GRBP)-assisted areas in Nigeria, Cameroon, Uganda, and collaborative programs in Latin America and Sudan

Country/Tx Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	TOTAL	% ATO	% ALL GRBP TX	
<b>NIGERIA</b> *ATO(serp)	4,866,900				7,712											
TX(serp)	2,630	3,918	199,969	199,437	344,347	661,853							1,287,630	30%	69	
TX(ser)			187	261	476	1,573							2,597	33%	62	
<b>UGANDA</b> *ATO(serp)	906,890				1,899											
TX(serp)	12,630	990	779	156,414	97,524	190,267							418,860	49%	19	
TX(ser)				490	162	308							961	52%	30	
<b>CAMEROON</b> ATO(serp)	1,826,699				2,811											
TX(serp)					71,398	177,896							249,094	24%	11	
TX(ser)					282								282	11%	9	
<b>OEPA*</b> ATO(serp)	418,188				1,891											
TX(serp)				198,339									198,339	46%	8	
TX(ser)				1,652									1,652	55%	22	
<b>SUDAN</b> ATO(serp)	488,232				963											
TX(serp)	207	252	900										1,359	0%	6	
TX(ser)																
<b>Totals</b> ATO(serp)	7,419,440				14,748											
TX(serp)	18,878	4,260	352,879	355,891	513,568	1,946,645	0	0	0	0	0	0	2,238,090	30%	109	
TX(ser)	0	0	1,250	771	821	1,912	0	0	0	0	0	0	4,854	33%	199	

ATO: Annual Treatment Objective, TX: Number Treated, serp: Eligible At Risk Population, ser: At Risk Villages (mass Mectizan treatment is provided)  
 pvt: Passive Treatment Villages (clinic based treatment only)  
 \*OEPA figures reported quarterly  
 Number of ser and pvt villages in Sudan are not clearly defined

## Trachoma Prevalence Survey in Sudan

As a first step in launching a national trachoma control program, the Federal Ministry of Health of Sudan sent a team of ophthalmologists and epidemiologists to two regions to assess the prevalence of trachoma.

Although several reports of trachoma in Sudan have been published, this was the first large-scale, population-based survey. The prevalence of trachoma in both regions suggests that trachoma is a significant public health problem in Sudan.

The surveys were conducted under the direction of Professor Mamoun Homeida, Academy of Medical Sciences and Technology, chairman of the National Onchocerciasis Task Force, and a member of the newly formed National Trachoma Technical Consultative Committee. The two survey areas were Wadi Halfa, near the border with Egypt, and Malakal, along the Sobat River in southern Sudan. The survey team included an epidemiologist and two ophthalmologists from the Federal Ministry of Health. Professor Charles Mackenzie of Michigan State University and Carter Center consultant assisted the team.

As Professor Homeida reported at the first Trachoma Program Review in Atlanta, the prevalence study was conducted in 10 villages in Malakal and 14 villages in Halfa. A total of 4,800 people were examined. Stages of trachoma were recorded for each

individual using the World Health Organization (WHO) simplified trachoma grading scale. Preliminary results from both study areas showed very high prevalence of trachoma among the sampled population. The percentages of people with active inflammatory trachoma (TF/TI), trichomatous scarring (TS), and trichomatous trichiasis (TT) are shown below. In addition, the preliminary data show that 11 percent of all women 40 years of age or older have TT.

WHO classifies trachoma as a “serious public health problem” if:

- Greater than 20 percent of children 1-10 years have TF/TI
- Greater than 30 percent of women 30 years of age or older have TS
- Greater than 1 percent of women 40 years of age or older have TT

These two Sudan prevalence surveys are an important step in the fight against blinding trachoma. They were funded through the generosity of the Conrad N. Hilton Foundation and were an important part of The Carter Center’s proposal to Lions Clubs International for support to fight blinding trachoma in Sudan.

As a result, the new Lions-Carter Center SightFirst initiative includes support for launching and sustaining Sudan’s trachoma control program. Along with their ongoing support for onchocerciasis control, this is another important humanitarian effort to prevent blindness in Sudan by Lions Clubs International. The national trachoma control program plans to

launch its village-based interventions in the Malakal area in August 2000, using the SAFE strategy. The strategy, developed by WHO with support from the Edna McConnell Clark Foundation, involves:

- Surgery to correct blindness from advanced trachoma
- Antibiotics to treat early trachoma infections
- Face and hand washing to prevent transmission of trachoma
- Environmental changes to improve hygiene and sanitation.★

## Partners in Trachoma Control to Test Surveillance, Monitoring Indices

Thanks to the efforts of the GET 2020 Alliance and key donor organizations, numerous national trachoma control programs have been launched in the past few years.

In recent meetings, it has become apparent that few national programs are collecting and reporting data which can be compared with trachoma control programs of other countries. As a result, there is a keen interest in establishing standards for program surveillance, monitoring, and evaluation. This topic was discussed during the first annual program review for Carter Center-assisted trachoma control programs, held at The Carter Center in February.

A provisional set of eight simple, reliable, and flexible indicators for trachoma control programs was proposed for discussion and testing:

- Percent of women over 40 years old with trichomatous trichiasis (TT)

Study Area	TF/TI (%) (1- 10 years)	TS (%) (Women >30 years)	TT (%) (>14 years)
Malakal	45	86	10
Halfa	47	87	2

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## Trachoma Control Tests

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- Percent of children 1-10 years old with active inflammatory trachoma (TF/TI)

- Percent of TT target population having received surgery

- Percent of TF/TI target population treated with antibiotics

- Percent of target villages having received health education

- Percent of children 1-10 years old with clean faces (no ocular or nasal discharge, or flies on face when observed)

- Percent of endemic communities with most (>50 percent) households having a toilet in house or covered latrine available

- Percent of endemic communities with most (>50 percent) households having a water source within 1 kilometer of the household.

The challenge to trachoma control programs is to choose indicators which will emphasize positive, quantifiable attributes of the programs and which will provide meaningful information to decision makers.

Well-chosen indicators should be useful in the first years of the program for describing the extent and severity of trachoma in communities, and for maintaining a focus on program targets.

For example, in choosing a measure of trichiasis surgeries done, the number of surgeries performed is given more meaning by its expression relative to the number of surgeries that need to be performed (the program target). This can be expressed as “percent of the TT target population having received surgery.”

Monitoring and evaluation indicators must be meaningful when tracked over time and across national borders, revealing trends in both the epidemiology of trachoma and program implementation. The choice of indicators of positive progress, e.g., percentage of clean faces, as

opposed to dirty faces, will demonstrate the program’s progress in a way that will be meaningful to decision makers and program advocates as well as the people the programs need to reach — village chiefs, elders, and those at risk for trachoma.

At the end of the program review, representatives of participating countries planned to adapt and test monitoring and evaluation indicators in their countries beginning this year.★

## Pfizer Donates Zithromax® for Sudan’s Trachoma

It was a memorable July for Sudan’s Trachoma Control Program. In collaboration with The Carter Center and the International Trachoma Initiative (ITI), Pfizer Inc. announced its donation of enough Zithromax™ (azithromycin) to treat 11,000 people for trachoma in the highly endemic area around Malakal in southern Sudan. The Zithromax™ is scheduled to arrive in Khartoum in early August 2000, and the community treatment campaign will begin later in the same month. The donation will be made through the ITI, the organization authorized to distribute Zithromax for trachoma.

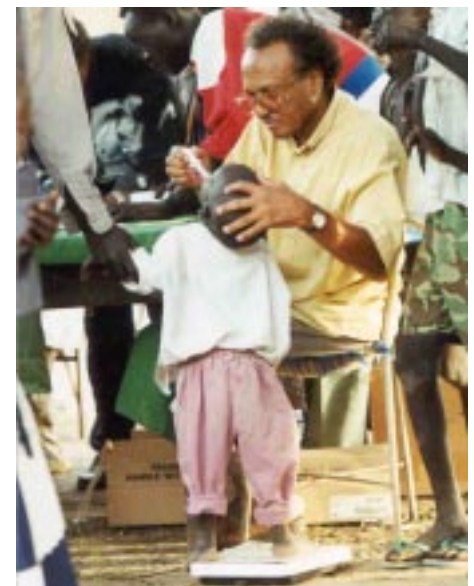
The generosity of ITI/Pfizer Inc., coupled with the new grant from the Lions-Carter Center SightFirst Initiative, complements the motivation and expertise of Sudan’s Trachoma Technical Consultative Committee (TCC), making possible the launch of the complete SAFE strategy in the Malakal area. The ITI has invited Sudan’s TCP to apply for ongoing support, including expanded work in other endemic areas of the south and Wadi Halfa in the north.

Also in July, a member of Sudan’s Trachoma TCC, Dr. Malik Ali Abdel

Gadir, headed a delegation to Malakal to prepare the community to fight trachoma. Dr. Malik’s team met with high-ranking government officials and community leaders, and completed a knowledge, attitudes, and practices (KAP) survey of villagers. In addition, 44 village volunteers were trained in community-directed azithromycin treatment.

Dr. Malik’s team then led a workshop titled “Save Our Children from Blindness,” to mobilize the people of Malakal. The workshop was a great success, thanks, in part, to support from UNICEF and the Sudanese Red Crescent Society.

Dr. Malik said, “[The workshop] was honored by [the presence of] the State Wali (governor), Dr. Yonas Bol De Manial, and the Minister of Health, Mr. Peter Pal, plus other cabinet members.” The Wali gave full support to the Ministry’s efforts to implement the entire SAFE strategy in Malakal, with an emphasis on the “F” and “E.” His firm words were aired on Voice of Peace radio. His Excellency also directed the Minister of Education to emphasize “[school children’s] health, especially face cleaning in the morning.”★



*Professor Homeida gives Zithromax™ to a child, launching the Sudanese Trachoma Control Program.*

J. Zingser

## Milestones

### Headquarters

**Rachel Barwick**, Ph.D, has accepted the post of trachoma control program epidemiologist. Dr. Barwick, who recently completed services as an Epidemic Intelligence Service (EIS) officer at the Centers for Disease Control and Prevention (CDC), will join The Carter Center in August 2000 at the end of her CDC fellowship. Welcome, Dr. Barwick!

### Cameroon

We are pleased to welcome **Desire Menyeng Adolphe** as the new GRBP officer in Cameroon. Adolphe will travel frequently to Garoua in North Province to assist the project

there being carried out in partnership with the Ministry of Health and APOC. Welcome!

### Latin America

**Dr. Keith Carter** (PAHO), **Jack Blanks** (Project HOPE), and **Dr. Giovanini Coelho** (Brazil) will be leaving the Program Coordinating Committee (PCC) of OEPA. We would like to thank them for their valuable service and OEPA support.

### Sudan

The resident technical advisor (RTA) of the Global 2000 River Blindness Program and the Guinea Worm Eradication Program serving south Sudan, **Bruce Ross**, recently left his position with Global 2000 in Nairobi. Ross had been on loan since 1998 from the CDC

to serve as the Nairobi RTA during which time he made valuable contributions to the implementation of community-directed treatment with ivermectin in south Sudan. Ross returned to the CDC in Atlanta. We wish him every success.

We are pleased to welcome **Kelly Callahan** who replaces Ross as RTA. Callahan was the Global 2000 field coordinator for south Sudan for the past year. She has strong field experience in the Guinea worm and river blindness programs. Welcome!

### Niger

**Salissou Kane**, Carter Center RTA in Niger, recently became a member of Lions Clubs International. Congratulations, Lion Kane!

## Meetings

**The African Programme for Onchocerciasis Control (APOC) Technical Consultative Committee (TCC):** From February 28 to March 3, Dr. Frank Richards, GRBP, attended the ninth (Feb. 28-March 3) and tenth (June 26-28) meetings of TCC in Ouagadougou, Burkina Faso. Among other items, TCC approved the Ethiopia plan of action and a proposal for Mectizan distribution in Kafa Sheka Zone in partnership with Global 2000 and the Lions Clubs under the Lions-Carter Center SightFirst Initiative.

**World Health Assembly (WHA):** Dr. Mauricio Sauerbrey, Director of the Onchocerciasis Elimination Program for the Americas (OEPA) attended the WHA May 15-20 in Geneva. During the meeting he was aided by Sir George A.O. Alleyne, M.D., Director,

Pan American Health Organization (PAHO), and Dr. David Heymann, Executive Director, Communicable Diseases, in conducting productive individual meetings with all of the representatives of the six onchocerciasis endemic countries in the American region (Brazil, Colombia, Ecuador, Guatemala, Mexico, Venezuela).

**The 15th Meeting of the International Coalition of Nongovernmental Development Organizations Involved in Ivermectin Distribution (NGDO Coalition):** The NGDO Coalition meeting, chaired by Dr. Christine Godin of l'Organisation pour la Prevention de la Cecite, was held in Ouagadougou on Feb. 26-27.

**Ghana Trachoma Task Force Meeting:** Dr. James Zingeser and Misrak Makonnen attended the April 26 Trachoma Task Force meeting in Accra, Ghana. The national trachoma

program coordinator and other Ministry of Health staff attended, along with representatives of partner organizations such as WHO, Swiss Red Cross, and SightSavers International. The coordinator announced the approval of the Ghanaian ITI application, the results of The Carter Center-supported KAP study, and the next steps for developing health education strategies.

**International Alliance for Prevention of Blindness meetings:** Dr. James Zingeser, Carter Center senior epidemiologist, attended the International Agency for the Prevention of Blindness (IAPB) Task Force meeting in Paris Feb. 17-19. The task force discussed applications for membership and grants, as well as the launch of Vision 2020 – The Right to Sight activities in Bamoko and Pretoria for Francophone and Anglophone Africa, respectively.



