

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 for 1999 at River Blindness Program Review

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

Charles MacKenzie

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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 Goepf, 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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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 2001.

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 Mectizanfi 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 Mectizanfi 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

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 Mectizanfi, 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),

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,

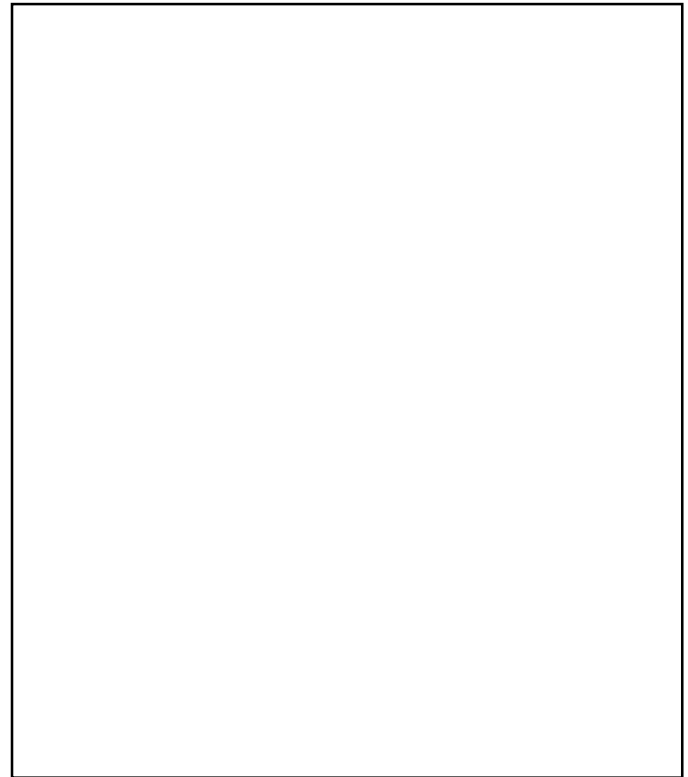
provided more than 71,398 treatments in North Province. No treatments have yet been reported by the GRBP-assisted program in West Province.

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). H







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), trachomatous scarring (TS), and trachomatous 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.^H

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 trachomatous 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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