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Guatemala, and Ecuador announced they would halt Mectizan treatment in 2008 in Lopez de Micay, Escuintla, and Rio Santiago. These are in addition to the Santa Rosa focus in Guatemala, which was the first to stop Mectizan treatments in 2007. The OEPA Program Coordinating Committee

considering the recommendation that they stop treatment in North Chiapas. The Colombian focus is particularly noteworthy since it is the only endemic focus in that country.

“This remarkable progress would not be possible without the dedicated health workers and volunteers working at the community level and the invaluable public-private partnership with Merck and the Mectizan Donation Program,” said former U.S President Jimmy Carter. “Because of this vital collaboration . . . continued progress can be made to wipe this debilitating disease from the hemisphere.”

This year will be the second in which the remote sTe 200.8736 527.0334 Tm(-)TjETBT/a

commission to approach this binational problem in a unified way, as the Yanomami area poses the greatest threat to complete onchocerciasis elimination in the Americas.

An additional outcome from the conference was the need for a new resolution, since 2007 was declared as the year for all new onchocerciasis eye disease to be eliminated under a 1991 PAHO resolution. (Nine of the 13 foci have achieved this goal.) IACO 2007 and the country programs called for completion of elimination of all new onchocerciasis ocular morbidity as well as interruption of transmission throughout the Americas by 2012. OEPA will work with PAHO staff to submit these new goals as part of the PAHO 2008–2012 Regional Eye Health Plan and as a new draft resolution to be considered at the September 2008 meeting of the PAHO Directing Council.

IACO 2007, attended by 76 people, was convened by the Ministry of Health of Ecuador, the Carter

health workers voi4n93.093.c93.u93..5 2..093..53.u9

# River Blindness

Thanks to Uganda's launch of the elimination approach for onchocerciasis (see article on page 4), the need for timely, objective, and accurate information on the prevalence and transmission of the disease in affected areas became a high priority. An elimination program must demonstrate that there is no longer a

Organization Onchocerciasis Control Programme in West Africa. This molecular method is the most efficient, specific, and sensitive tool for monitoring and evaluation of onchocerciasis control programs in foci where transmission levels are low.

The Carter Center also has supported the laboratory with OV16 capability to assess the prevalence

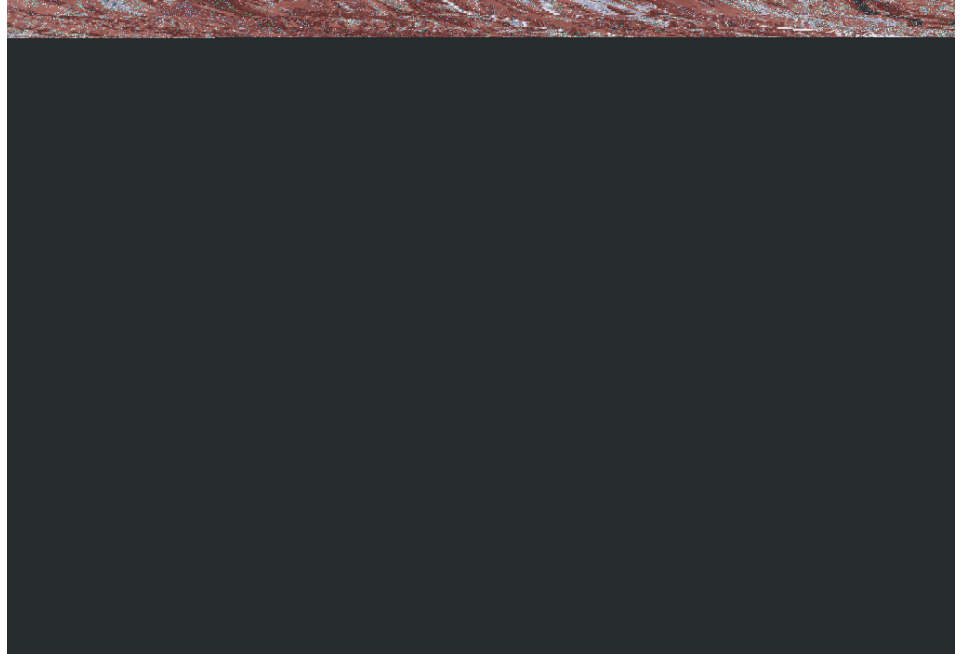
of onchocerciasis in human beings. Antibodies in the serum from patients with parasitological diagnosis of onchocerciasis react positively to OV16. It is a rapid mass-screening technique that the control program in Uganda will use to determine the prevalence of the disease in communities where other methods such as skin snipping are no longer sufficiently sensitive.

Working with Dr. Thomas Unnasch's laboratory at the University of Alabama–Birmingham (UAB), The Carter Center sponsored a newly recruited biomedical scientist at the new laboratory in Uganda, David Were Oguttu, to undergo practical molecular epidemiology training. The training covered a range of laboratory techniques related to PCR and OV-16. Mr. Oguttu is expected to train his colleagues back in Uganda.

# River Blindness

Although onchocerciasis levels in Uganda have been reduced considerably since 1996, the threat of recrudescence among at least 2 million people still remains. That possibility, coupled with a fear of donor fatigue, led the government to re-establish a policy for onchocercia-

# River Blindness



the people involved put aside trivial demands and distractions, work in a

systematic and timely fashion, and are passionate about finishing the job.

**T**he Carter Center has received a grant from the Bill & Melinda

# Trachoma

**I**n July 2007, the Trachoma Control Program began to integrate its

# Trachoma

## T P S

In July 2006, the sub-kebele of Fek Ayil, situated in the highlands of the Amhara region of Ethiopia, began pulling water from its first protected water source. Living a two hours' walk from the nearest paved road, the 21 households in this small community had never before had access to a clean, regular, and protected water source.

Over the course of 2006, a total

of 113 protected water points were installed in Amhara with the support of The Carter Center, the Ethiopian Lions Club, and Christoffel-Blindenmission. The Organization for the Rehabilitation and Development of Amhara was tasked to locate communities, coordinate construction, and train local water management committees.

In June of 2007, The Carter

Center evaluated the sustainability and functionality of a random sample of 30 water points in four zones: East Gojjam, West Gojjam, South Gondar, and North Gondar. When the evaluation team visited Fek Ayil, they were impressed by the level of

organization and commitment shown by the community management committee and the volunteer guardian, Simegn Alem.

When asked why she was chosen to be the water point guard, she replied, "I live in the household nearest to the well, so it is no problem for me to open the gate when asked. I sometimes get discouraged by the responsibility, but I am willing to continue serving in this role because it is important.

"Without a guard, the pump could get damaged or water would be wasted," she added. The small community contributed all the labor for the water pump, including digging the well and carrying construction equipment by hand from the road to the village. The community selected five members to serve on a management committee. This group collects 1 birr per month from each household, which is deposited in a local savings account in the woreda capital. The community is able to use this savings to make loans and finance regular maintenance on the water pump as needed.

Before the water pump was installed, the inhabitants of Fek Ayil drank tala, a home-brewed beer, exclusively. "We use this water for all of our daily needs: cooking, washing, and drinking." According to Simegn, "Now our stomachs are clean and we drink safely without fear."

*This is the sixth in a series of articles showing the human face of the Carter Center Trachoma Control Program. The comments of the individuals highlighted are not reproduced word for word but reflect the spirit of our conversations with people in the field. The authors try to be faithful to the context, content, and tone of the people depicted.*



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In 2006 and 2007, The Carter Center in Southern Sudan has focused on expanding infrastructure to help better deliver program interventions. With this platform, the two health programs are better placed to respond to the needs of the Ministry of Health for the government of Southern Sudan, in addition to enhancing collaboration with other partners. The Guinea Worm Program staff have extensive local cultural knowledge, enabling them to deliver both programs at the same time.

GGaa



# Trachoma

In response to a 2005 study that found an average of less than 10 percent sanitation coverage in northern Ghana, with many communities lacking even a single latrine, The Carter Center began to support health districts in a unique latrine promotion program. The approach focused on ensuring 100 percent household latrine coverage in each village, regardless of a household's wealth, status, or ability to provide labor. In December 2006, The Carter Center evaluated the latrine promotion program through a household survey in a random sample of supported villages in the Northern region.

Twelve communities that had participated in the Carter Center-supported latrine promotion program for at least 12 months were randomly selected from two districts. A total of 327 households were interviewed to determine demographics, access to a household latrine, perceptions of latrines, and construction costs. A visual inspection of all latrines also was conducted to determine latrine use and construction status.

Altogether, 88 percent of the households surveyed had a usable latrine, and 65 percent had latrines



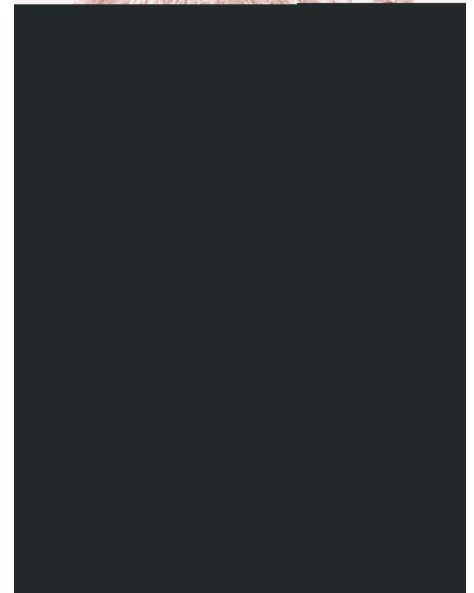
# Trachoma

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been advised to build one. The major reasons given for not building a latrine were cost, lack of time, and inability to provide labor. Despite this, 100 percent of these households stated an intention to build a latrine in the future.

Both households that owned a usable latrine and those that did not were knowledgeable about the advantages and disadvantages of owning a latrine. The most commonly stated advantages of owning a latrine were convenience, health benefits, lack of feces around the compound, and privacy. The disadvantages stated were latrine maintenance, a bad odor, the high cost, and a risk of collapse.

This evaluation found that in Carter Center-assisted communities in the Northern region of Ghana, household latrine coverage has increased from 0 percent to 88 percent of households having a usable latrine over a two-year period. In addition, feces were found in 71 percent of the latrines, showing that a majority of households in the communities have adapted their behavior. There is a need for heightened health education and behavior change activities that the program will continue to address. The latrine promotion program increased latrine access and use in all selected communities and should be encouraged as a model for other latrine programs in northern Ghana.



J. K. S.

## M L S , G T

In collaboration with Mali's National Program for Blindness Prevention and local Lions Clubs in Mali, The Carter Center has undertaken the training of 800 women to strengthen health education in Ségou and Mopti regions. In 2007, the four



Lions Clubs in Bamako (Soukala, Malina, Yelé, and Sigui) made a joint award of 8 000 000 CFA francs (approximately \$17,777) to carry out training activities targeting active women community leaders. The award was of locally raised money, and by

April 2008, the program will train five women leaders from 160 already existing women's groups: 600 women from Ségou and 200 women from Mopti region.

With the knowledge that trachoma disproportionately affects women, the program initiated this important activity to focus on empowering women to educate their peers about the risks of trachoma. Key

community women were selected from each women's group to be trained as health educators, specializing in trachoma education targeting women and children. Their training focuses on trachoma prevention through the F and E components of the SAFE strategy for trachoma control as well as treatment of trachoma using antibiotics and surgery.

The trained women are responsible for monitoring hygiene and sanitation practices in their households and in their community after the training. Among the five women chosen per group, a minimum of two are literate to ensure they can fill out monitoring notebooks and use the health education materials after the training. The Carter Center Mali also has developed health education materials in local language for the women's use. The Carter Center assistance to the Mali Trachoma Program is supported by the Conrad N. Hilton Foundation.

In early 2007, The Carter Center was invited to help distribute 3 million long-lasting insecticidal mosquito nets in three regions of Ethiopia as a contribution to the country's target of 20 million nets distributed before the new Ethiopian millennium, September 2007. Before doing so, the Center wanted to establish the baseline level of net ownership in the country as well as the extent to which people use their nets. It also wanted to know the

Since Feb. 8, 2007, when the first Carter Center-sponsored long-lasting insecticide-treated net (LLIN) was distributed in Mana, a malarious endemic district in the region of Oromiya, Ethiopia, an additional 2,960,070 LLINs have been delivered to approximately 1,480,000 households. As a result, the Center has completed 98.7 percent of its commitment to distribute 3,000,000 LLINs across Amhara, Oromia, and Southern Nations, Nationalities and Peoples' regions.

Within the zones where the Trachoma Program (all 10 of the Amhara region) and River Blindness Program (Kaffa, Sheka, Bench-Maji, North Gondar, Illubabor, Jimma, Gambella, and Metekel zones) were already working, an estimated 4,940,000 people have been provided with protection against malaria through this collaborative effort with the Ministry of Health of Ethiopia.

Additionally, the Center is working with ministry officials to enhance health education efforts at the community level through the development of four key messages that emphasize the ministry's focus in malaria control:

1. Give priority for LLIN use to pregnant women and children less than 5 years old.
2. Sleep under an LLIN every night.
3. Properly hang mosquito nets (with insecticide) over the bed.

