

EYE EAGLE

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~~Waging Peace, Fighting~~

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What's Inside

Carter Center to assist the Nigerian Ministry of Health to eliminate river blindness from seven states — Abia, Anambra, Ebonyi, Edo, Enugu, Delta, and Imo — by 2020.

At the meeting, the Carter Center's

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Trachoma Program Reveals 2014 Statistics for Surgery, Other Treatments

The 16th annual Trachoma Program

Review was held at The Carter Center in Atlanta, Ga., March 2–4, under the theme of “Looking Back, Moving Forward.” The review provided an opportunity to assess the status of each national program and their progress toward meeting elimination goals. This year, participants focused on lessons learned over the past 15 years and how this knowledge can inform the global trachoma community as it moves toward elimination of blinding

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Trachoma Impact Surveys Show Reduction in Two Nigerian States

Trachoma baseline prevalence surveys conducted in 2007 and 2008 in Nasarawa and Plateau states in Nigeria evidenced the need for SAFE interventions in seven local government areas (LGAs) including the need for three rounds of mass drug administration (MDA) (Figure 1). Following these three MDA rounds, the Nigerian Ministry of Health supported by The Carter Center, through funding from the ENVISION project led by RTI International, conducted community-based impact assessments in April and May 2014. These impact assessments evaluated the impact of the SAFE strategy on the elimination of blinding trachoma as a public health problem and further assessed if these two states met the World Health Organization (WHO) elimination thresholds.

The current WHO thresholds for the elimination of blinding trachoma as a public health problem require that each country reduce the number of people with trachomatous trichiasis (TT) known to the public health system to fewer than one per 1,000 people in a district, and the number of

cases of active trachomatous inflammation follicular (TF) in children ages 1–9 years must be less than 5 percent of the population of children in the districts.

A multistage cluster-random sampling was used to survey 29 LGAs in Nasarawa and Plateau states. One LGA, Wase, was not surveyed as the area was inaccessible by survey teams. Three types of enumeration units (EUs) were included in the survey: 1) subdistricts, 2) districts, or LGAs, and 3) superdistricts. LGAs with baseline TF prevalence greater than 10 percent were surveyed at the subdistrict level; LGAs with baseline TF prevalence between 5 and 10 percent were surveyed at the district level; and LGAs with baseline TF prevalence less than 5 percent were aggregated by state and surveyed as a superdistrict.

In total, 30 EUs were surveyed. In three of the 30 EUs, the prevalence of TF among children ages 1 to 9 was between 5 to 9 percent. The prevalence of TF among children ages 1 to 9 was less than 5 percent in the remaining EUs. However, it should

be noted that the sample size was not achieved in the three EUs where TF prevalence was greater than 5 percent. This occurred because not all selected clusters in the three EUs were surveyed; the population residing in those clusters had been internally displaced. Overall, the impact assessments documented a reduction in prevalence of TF among children ages 1 to 9 in all areas compared to baseline.

The prevalence of TT among adults ages 15 years and older decreased in all EUs compared to baseline. Results indicated that all but seven EUs surveyed had reached the elimination threshold of less than one case per 1,000 total population.

Results from the trachoma impact surveys evidenced that trachoma has decreased in Nasarawa and Plateau states since the baseline surveys in 2007 and 2008. These results show that after years of partnership between The Carter Center and Nigeria's Ministry of Health, Plateau and Nasarawa states have made significant progress in reducing the risk of blinding trachoma. **E**

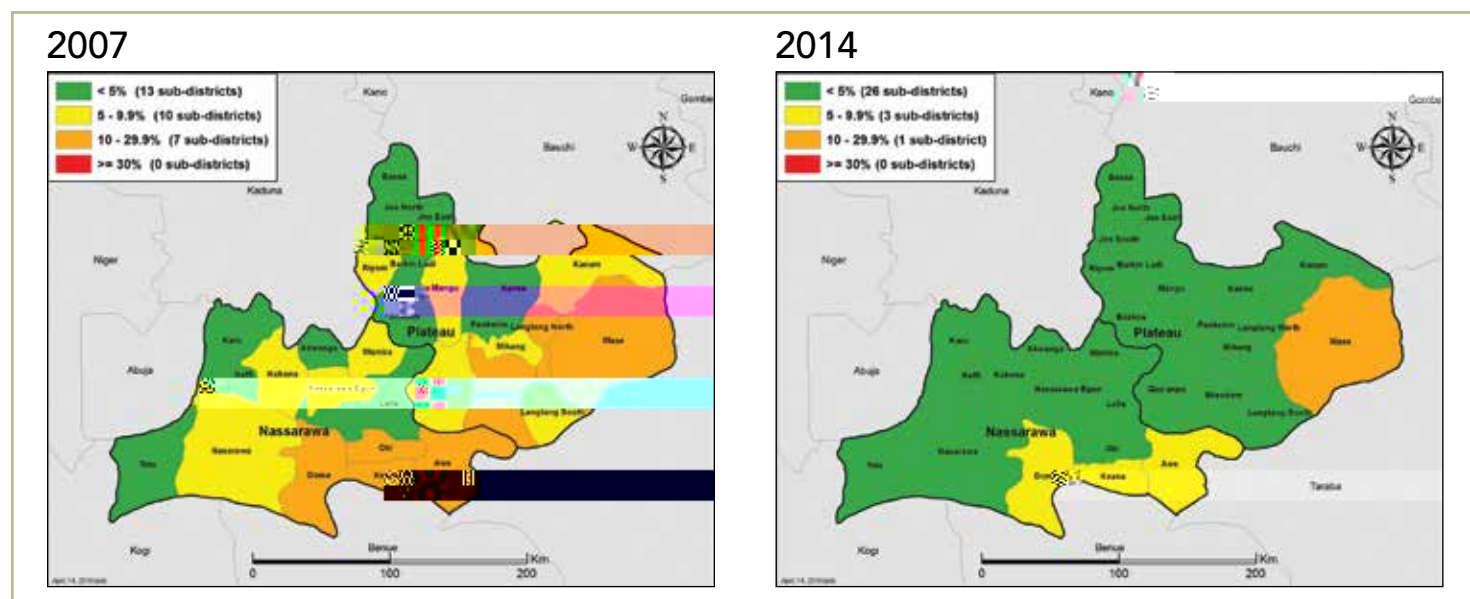


Figure 1. TF prevalence among children ages 1–9 years in two Nigerian states: Plateau and Nasarawa.

Community Participation Inspires Longtime Health Worker

We met **Tibeltalech Kifelie** in the village of Wonchit in the South Gondar zone of the Amhara Region of Ethiopia during an annual trachoma campaign for mass distribution of antibiotics for trachoma control.



Health extension worker Tibeltalech Kifelie provides a

Tibeltalech has worked as a health extension worker in the district for the past nine years, including supporting nine rounds of mass distribution of antibiotics. She said she was a recent arrival in Wonchit, working in the community for only two months prior to the January 2015 mass drug administration, but the community's

eagerness to participate in the distribution impressed her.


In preparation for this annual mass distribution, a one-day training session attended by Tibeltalech was held a week before the event for an estimated 12,000 health workers who would be assisting with the distribution. Her efforts as a health worker are supported by the Health Development Army, a network of community volunteers and model family households that support health activities throughout Ethiopia. With the support of these volunteers, Tibeltalech announced the January drug distribution date at community forums and churches to people living in her catchment area, known as a *kebele*. Together, they were able to successfully convey the importance of this event to the roughly 5,000 people in the *kebele*.

When we visited Wonchit in the middle of the weeklong distribution campaign, Tibeltalech and a team of Health Development Army volunteers had distributed drugs in three of the five villages within the *kebele*. Tibeltalech credited strong social mobilization as the reason that community members were very willing

to take the drugs, and, for that reason, she anticipated that her team would well exceed their goal of 80 percent coverage.

Tibeltalech said she was passionate about providing “health education on the 16 health extension packages [that workers are tasked with supporting] and encouraging behavior change.” She noted that behavior change remains the most challenging component of her job, describing how community members are very willing to accept education, but actual behavior modification takes longer. However, Tibeltalech noted, behavior change does, in fact, occur.

Finally, Tibeltalech said that over the last several years the willingness of community members to participate in annual mass drug administration campaigns has increased, and community members have noticed that the “medicine brings relief.” Because of the efforts of Tibeltalech, other health extension workers, and the Health Development Army volunteers throughout Amhara, over 16 million people have benefited from annual treatment with azithromycin since 2008.

This article is part of an ongoing series about how the Carter Center's Trachoma Control Program affects individuals in the countries where it works. Comments are not reproduced word for word, but typify the spirit of the conversations. The author has tried to be faithful to the context, content, and tone of the person depicted. 

In November 2014 the Uganda Ministry of Health launched a new trachoma program in two regions as part of the Queen Elizabeth Diamond Jubilee Trust's Trachoma Initiative in Africa.

In Uganda, trachoma is endemic in 36 of 112 districts, where an estimated 10 million people, or one-third of the population, reside. Uganda

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SAFE strategy for trachoma control (which includes surgery, antibiotics, facial cleanliness, and environmental improvement), the Ministry of Health, with the support of United States Agency for International Development (USAID) and the ENVISION project led by RTI International, is conducting mass drug administration in endemic districts. Drug distribution also serves as an opportunity to inform the community about the availability of surgery

The new initiative was officially launched on Nov.18 during a community-based ceremony in the district of Jinja in the Busoga region. The guests of honor included the minister of health, Hon. Dr. Tumwesigye Elioda, who said the ministry would do everything necessary to ensure the target date of 2020 would be reached. During this event, Dr. Elioda also launched the country's Trachoma Action Plan as a roadmap for reaching the 2020

In 2014, the Carter Center's River
Blindness Elimination Program assisted

is donated by GlaxoSmithKline.

Treatments for soil-transmitted helminths also experienced a great increase in 2014, with 7,700,653 treatments given in areas assisted by The Carter Center in Nigeria, nearly 10 times the amount given in 2013. The 2015 target is 10.4 million. The medicines used for soil-transmitted helminth treatment are donated by GlaxoSmithKline (albendazole) and Johnson & Johnson (mebendazole).

The Carter Center assisted in 2,756,257 praziquantel treatments for schistosomiasis in Delta, Ebonyi, Enugu, Edo, Nasarawa, and Plateau states in 2014. The majority of the praziquantel used was donated to The Carter Center through the World Health Organization by Merck KGaA (E-Merck) of Germany. Complementing USAID funding, the Izumi Foundation supports this program in four of the six states. The treatment target in 2015 is 831,430;

this is lower than 2014 due to World Health Organization guidelines, which call for treatment every other year in some areas.

Uganda

The Uganda program administered 3.3 million Mectizan

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treatments for soil-transmitted helminths in Uganda. The program administered 3.3 million Mectizan

in 2014, which is a significant increase from 2013. The program is targeting 8 million treatments in 2015.

In Memoriam Aseged Taye (1963–2015)

River Blindness Officer

It is with great sadness and regret that The Carter Center announces the sudden passing of Aseged Taye Zeleke on May 23, 2015, in Addis Ababa, Ethiopia.

Aseged was the only son of father Taye Zeleke and mother Seblework Mekuria. He attended Haile Degaga Elementary and Comprehensive High School in Arba Minch and attended Addis Ababa University (AAU) in 1980, graduating with a Bachelor of Science degree in biology in 1984. After graduation Aseged worked as a teacher in the rural areas of Ethiopia from 1984–2000. While teaching, he

continued his studies at AAU, obtaining a master's degree in 1995.

Aseged worked from 2000–2009 at the Ethiopian Health and Nutrition Research Institute as researcher and team leader in the parasitology and vector biology team. He then moved to RTI International, where he worked from June 2009–July 2010.

In October 2010, he joined The Carter Center, where he was employed until the time of his death. During his tenure as a river blindness program officer, he was known for his organization, competence, and determination. He contributed much to the office, transferring the skills he acquired through training, voracious reading, and robust fieldwork. Aseged was a quiet, unsung hero who will be dearly missed by The Carter Center and his beloved family and friends. We extend

our condolences to his son and his extended family and friends. ■



Aseged Taye

River blindness (onchocerciasis) transmission is a cross-border problem between neighbors Ethiopia and Sudan, specifically in the frontier between Metema *woreda* in Ethiopia and Gallabat in Sudan (see Figure 4). Recently, binational teams composed of members from the ministries of health of both countries have set an impressive example of collaboration by working together to collect over 6,000 blood samples.

Laboratories in each country will test these samples (3,000 on each side of the border) for Ov16 antibody, following the same protocol and under the auspices of the laboratory at the University of South Florida. If the specimens are negative, it could lead to a cross-border determination that onchocerciasis transmission has likely been halted, and a binational, coordinated decision to stop mass drug administration.

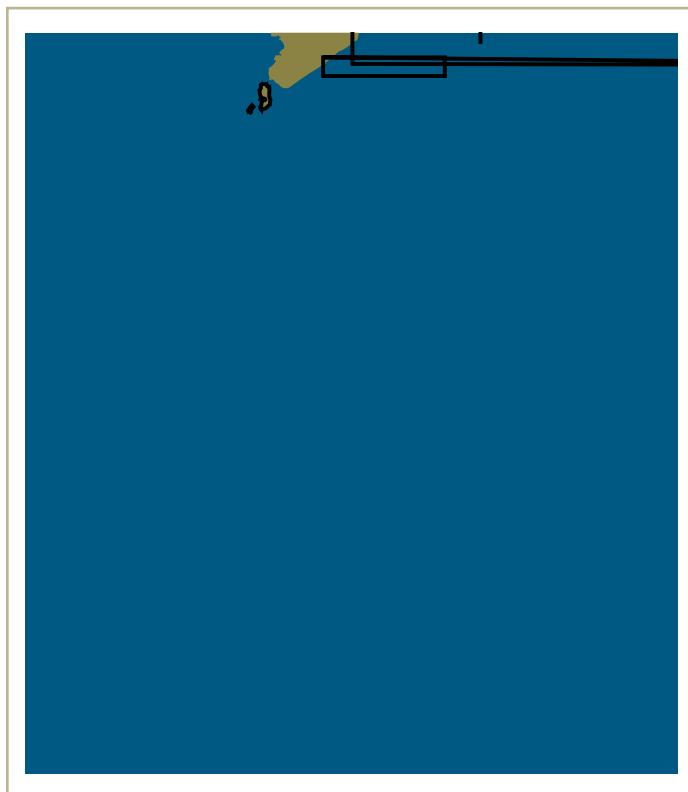
Success in disease control or elimination across international borders in Africa has so far been rare and difficult to replicate from one region to another. Yet the need to tackle diseases with cross-border transmission is critical if the goal of onchocerciasis elimination is to be realized. The Ethiopia-Sudan example shows how onchocerciasis programs can strengthen relationships between

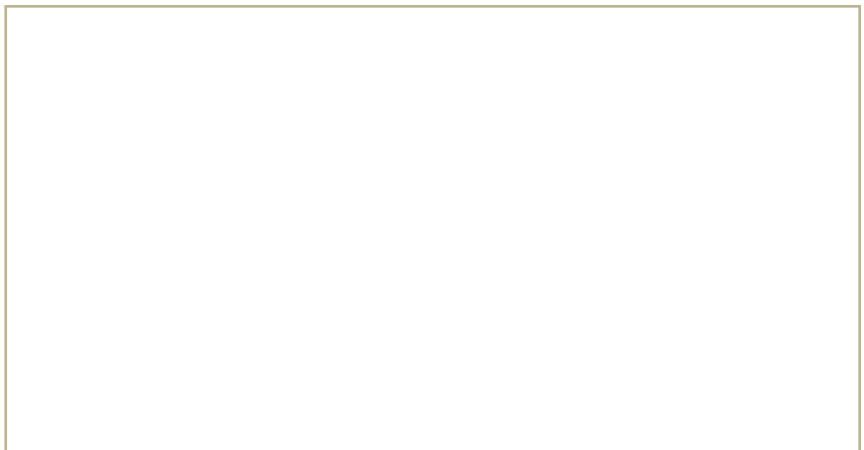
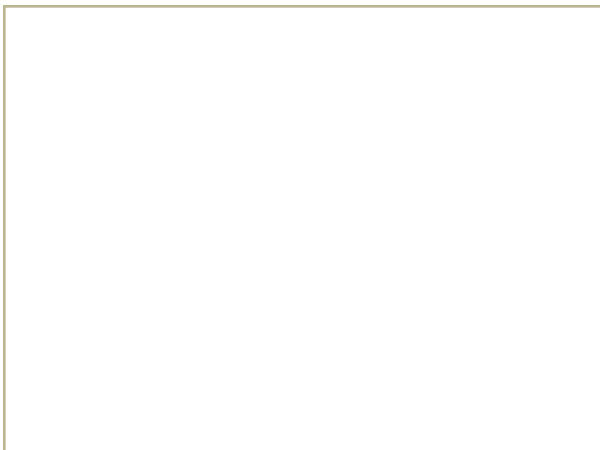
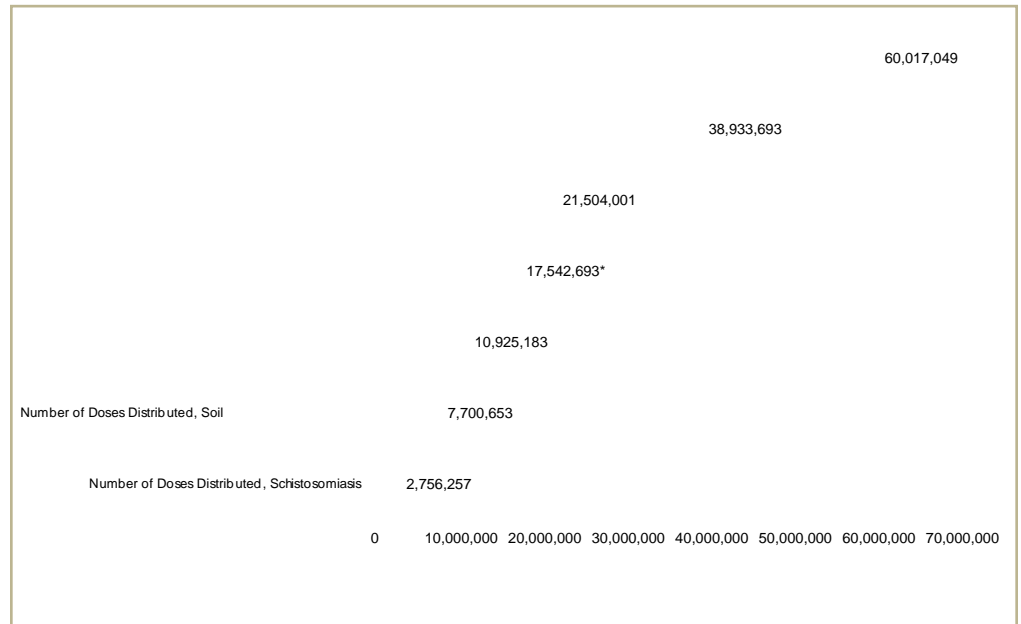
neighboring countries, resulting in a common stand against disease threats.

Both governments, through their ministries of health, pursued a homegrown, simple, transparent, and effective approach to tackling cross-border onchocerciasis transmission. Local initiative and collegial relationships were able to drive the process, minimizing the need for drawn-out consultation with international agencies. The programs of both countries mobilized their technical teams, shared resources, secured invitation letters and visas for each other's team members, set specific and realistic objectives, and minimized bureaucratic red tape.

When a country team had more experience, effort was made to share that experience with the other team in a sustainable fashion. Plans were made to conduct epidemiological and entomological surveys as well as mass drug administration at the same time on both sides of the border. Periodic coordination meetings were held on each other's territory while "in the bush." Communication was regular and via email or mobile devices when the teams were not working together in the field.

This incredible partnership should serve as an example for other countries where disease transmission does not recognize political borders. Ethiopia and Sudan collaborate on a focal; Tewodros Seid, Carter Center-Ethiopia, statistician; the





The Carter Center
One Copenhill
453 Freedom Parkway
Atlanta, GA 30307

