



Eye of the Eagle



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IACO 2008: Two Guatemala, Mexico Foci Halt Treatment

Mexico and Guatemala agreed to stop Mectizan® treatments for onchocerciasis in two foci during the 18th annual Inter-American Conference on Onchocerciasis (IACO) in Oaxaca, Mexico, held Nov. 12–14, 2008. The Pan American Health Organization (PAHO) also announced a Directing Council resolution (CD48.R12) calling for interruption of onchocerciasis transmission in the region by 2012.

“The regional initiative uses a twice-per-year Mectizan treatment

Elimination Program for the Americas (OEPA). “It is vital that we encourage the endemic countries to prioritize onchocerciasis treatment and prevention. With the reinforced political will generated by this new PAHO resolution, along with hard work and



M. Hatch
Representatives of the local Lions Clubs who attended the IACO meeting. Back: Ramiro Peña Constanter, Kathryn Cabrera Coello, and Dr. Florencio Cabrera Coello. Front: Margarita Peña Constanter, Alfonso Barahona Herrarte, Kristen Eckert, Dr. Libardo Bastidas Passos, Dr. Ricardo Araujo Gurgel, and Vania Araujo Gurgel

What’s Inside

- Uganda Committee on Onchocerciasis Elimination 3
- In Memoriam: Abudulahi Oyabure Abu 4
- Onchocerciasis-Related Seizures Debate 5
- Review of Abu Hamad Elimination in Sudan 6
- First Maltra Week in Ethiopia 8
- Expansion of Niger, Mali Programs. . . 10
- Trachoma Field Officers in Ghana . . . 11

strategy and strives to exceed 85 percent coverage of all eligible persons every six months,” said Dr. Mauricio Sauerbrey, director of the Onchocerciasis

dedication, over the next few years it will be possible for a whole generation to grow up unhindered by vision

continues on page 2

Ghana Prevalence Surveys Show Trachoma Program’s Success

Since 2001, the Ghana Health Service has implemented the SAFE strategy in the endemic Upper West and Northern regions of the country, assisted by the International Trachoma Initiative, The Carter Center, and Pfizer, Inc. In late 2007 and early 2008, the impact of the

program was assessed through epidemiologically rigorous surveys in each of the 18 endemic districts. In each survey, all eligible household residents selected in the sample were examined for clinical signs of trachoma for a total of 74,225 people from 12,679 households. *continues on page 7*

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Waging Peace. Fighting Disease. Building Hope.

River Blindness

IACO

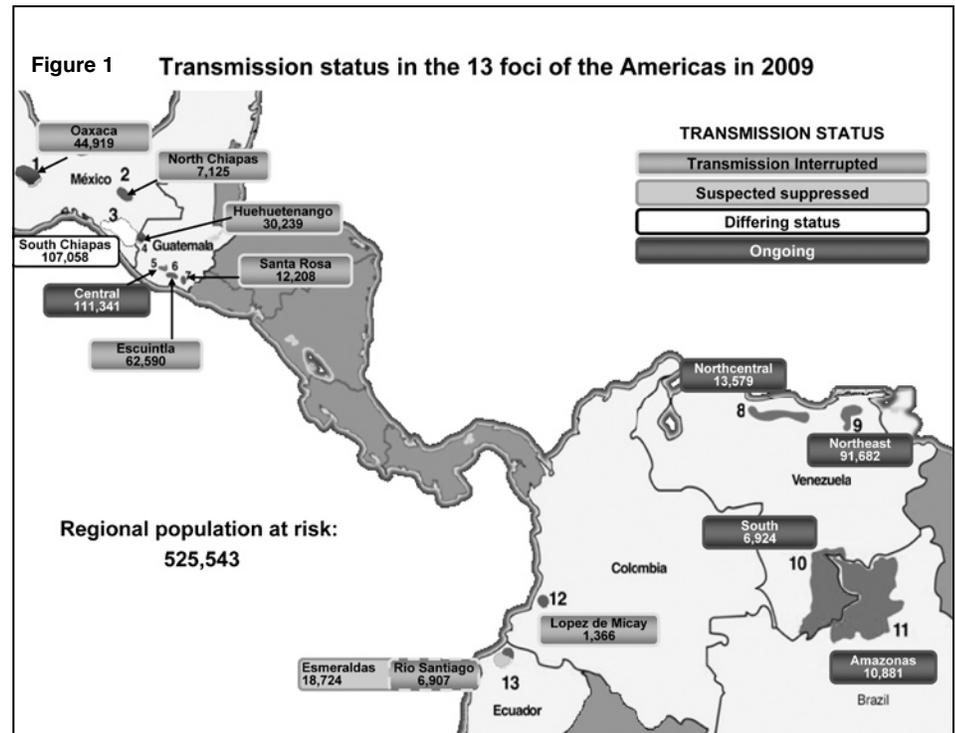
continued from page 1

damage or blindness from this disease and without need for taking further Mectizan treatments.”

Provisional 2008 Mectizan treatment reports (through September 2008) presented at the meeting showed a total of 567,612 Mectizan treatments. Coverage in the first round of treatment was reported to be 92 percent of the eligible population (364,890); the second treatment round for 2008 was not complete before the meeting.

To date, the program has halted treatment in six out of 13 foci, plus one subfocus in Ecuador (see Figure 1). Santa Rosa, Guatemala (Focus 7), was the first endemic area in the Americas to stop onchocerciasis transmission and halt Mectizan treatments in 2007. It was joined in 2008 by Lopez de Micay, Colombia (Focus 12, the only one in that country); North Chiapas, Mexico (Focus 2); Escuintla, Guatemala (Focus 6); and the Rio Santiago subfocus in Esmeraldas, Ecuador (Focus 13). At IACO 2008, the ministries of health of Mexico and Guatemala added Oaxaca (Focus 1) and Huehuetenango (Focus 4), respectively, to the preceding list. Because the meeting was held in Oaxaca, this generated great local excitement, and the story was picked up by local papers during the meeting. All foci must conduct posttreatment surveillance to monitor for any resurgence of onchocerciasis for at least three years after Mectizan treatments have been halted.

“We have the knowledge and ability to eliminate river blindness from the Western Hemisphere,” said former U.S. President Jimmy Carter. “To fail at this effort would be a great disservice to our



neighbors and a missed opportunity to improve lives in some of the world’s poorest communities.”

Ninety-eight people attended the meeting, convened by the Ministry of Health of Mexico, the Carter Center’s OEPA, and PAHO, with support from the Bill and Melinda Gates Foundation, the Lions Clubs International Foundation, and Merck & Co., Inc. A number of distinguished Mexican government officials attended the opening ceremonies, including Ulises Ruiz Ortiz, governor of the state of Oaxaca; Dr. Jose Angel Cordova Villalobos, minister of health of Mexico; Dr. Carlos Alvarez Lucas, deputy director general for preventive programs in Mexico; Dr. Martín Vasquez Villanueva, secretary of health of the state of Oaxaca; and Dr. Humberto Montiel, PAHO of Mexico.

Meeting participants included the directors of the six national onchocerciasis elimination programs in Brazil,

Colombia, Ecuador, Guatemala, Mexico, and Venezuela; representatives of the local Lions Clubs from five of the six countries (see photo on p. 1); Dr. Steven Ault, regional adviser on communicable diseases for PAHO-Washington; Ken Gustavsen, representing Merck & Co., Inc., which donates Mectizan; Dr. Ed Cupp, chair of the OEPA program coordinating committee; Dr. Julie Jacobson of the Global Health Program at the Bill and Melinda Gates Foundation; Dr. Adrian Hopkins of the Mectizan Donation Program; and Dr. Mark Eberhard, director of the Division of Parasitic Diseases at the U.S. Centers for Disease Control and Prevention. Nearly 25 Mexican field workers active in the national onchocerciasis elimination program joined the group, sharing their experience on the ground, including a unique health education used to encourage community enthusiasm and commitment to the Mectizan treatments.

Uganda Committee to Oversee Onchocerciasis Elimination

The Uganda Ministry of Health has established an international technical advisory committee to ensure that the government's recent onchocerciasis elimination efforts will be rigorously carried out and supported with good scientific data. Uganda adopted the elimination policy Jan. 31, 2007. Called the Uganda Onchocerciasis Elimination Committee (UOEC), the new committee held its first meeting Aug. 11–12, 2008, with

support from The Carter Center.

The terms of reference (TOR) for the UOEC draw heavily upon the experience of the steering committee of the Onchocerciasis Elimination Program for the Americas. UOEC responsibilities involve careful review of reports on programmatic activities from each focus targeted for elimination in Uganda (see Table 1); the committee will advise the Ministry of Health on focus-specific monitoring,

evaluation activities, and certification activities and will make recommendations on prioritizing activities to reach national goals. UOEC also will serve as a forum for the program partners to discuss key issues related to the national initiative. The UOEC is composed of 10 voting members: four at-large members; one member from the Ministry of Health; two district representatives; and one representative each from The Carter Center, Sight Savers International, and the African Program for Onchocerciasis Control (APOC). In addition, the Ministry of Health and The Carter Center provide

continues on page 4

Table 1 Elimination Classification of the 19 Uganda Onchocerciasis Foci Based on UOEC Meeting, August 2008

Onchocerciasis Classification	Focus	Districts
Eliminated	Victoria	Jinja, Mukono, Kamuli, Mayuge, Kayunga
Transmission interrupted	Itwara	Kabarole, Kyenjonjo
	Imaramagambo	Bushenyi
	Mpamba-Nkusi	Kibaale
	Wadelai	Nebbi
Elimination policy implemented, but transmission still occurring	Budongo	Bulisa, Hoima, Masindi
	Kashoya-Kitomi	Bushenyi, Ibanda, Kamwenge
	Kigezi-Bwindi	Kabale, Kanungu, Kisoro
	Mt. Elgon	Bududa, Manafua, Mbale, Sironko
	Wambabya-Rwamarongo	Hoima
Control activities are policy, but with more epidemiological information, there may be reason to implement elimination policy	Bondo	Arua
	Lubilia	Kasese
	Maracha-Terego	Maracha-Terego
	Nyamugasani	Kasese
	Obongi	Moyo
	Okoro	Nebbi
Not much information, security is poor, and/or crosses international borders into south Sudan or the Democratic Republic of the Congo; currently low priority for implementing elimination policy	Madi	Adjumani, Moyo
	West Nile	Arua, Koboko, Nebbi, Yumbe
	Mid North	Amuru, Gulu, Kitgum, Oyam, Pader

River Blindness

continued from page 3

two nonvoting co-secretaries to the committee. The Uganda representative of the World Health Organization and Lions Clubs of Uganda have observer status on the committee. The at-large members are Dr. Frank Walsh, professor Rolf Garms, Dr. Thomas Unnasch, and Dr. Ambriose Onapa.

The inaugural UOEC meeting, held at Imperial Royale Hotel in Kampala, was launched by Dr. DKW Lwamafa, commissioner for health services in the Department of National Disease Control. After examination of the TOR, the first order of business was the election of a chair. At-large member Dr. Frank Walsh, a seasoned medical entomologist, was unanimously elected by the committee members. The committee then reviewed Ministry of Health reports from the six foci targeted for elimination by semiannual ivermectin treatment and vector elimination where feasible or targeted vector control, namely: Budongo, Bwindi, Kashya-Kitomi, Mt. Elgon, Wadelai, and Wambabya-Rwamarongo. The committee also considered presentations from Itwara and Mpamba-Nkusi foci where GTZ (a German technical assistance agency) and APOC-supported vector elimination along with annual ivermectin treatment appear to have succeeded in interrupting the transmission of onchocerciasis.

The reports showed that the coverage of twice yearly ivermectin treatments was very successful with achievement of 90 percent of the ultimate treatment goal in each round during 2007 and the first half of 2008. Major recommendations included (a) moving Wadelai and Imaramagambo foci to “transmission interrupted” status



Attendees at the Uganda Onchocerciasis Elimination Committee meeting in Kampala, Uganda, Aug. 11–12, 2008.

because, in both cases, there is good evidence that transmission has ceased in the absence of larvicide application and (b) urgently obtaining updated entomological and epidemiological data in 2007–2008 from Itwara, Mpamba-

Nkusi, Wadelai, and Imaramagambo to allow consideration at the next UOEC meeting in 2009 for a possible recommendation for withdrawal of interventions in some or all of these foci.

In Memoriam

Abudulahi Oyabure Abu

The Carter Center is grieved by the death of Abudulahi Oyabure Abu, onchocerciasis project officer for Edo state in Nigeria. Abu served Edo state and The Carter Center as a state onchocerciasis control team member from 1993 to 1996. He then became the state project officer and contributed immensely in the successes of the Edo state Community Directed Treatment with Ivermectin (CDTI) program. During his tenure, Edo state accomplished a cumulative total of

6,527,876 Mectizan treatments. Abu’s advocacy efforts encouraged state and local government officials to make substantial budgetary allocations to the CDTI program. The Carter Center extends sympathy to his family, his colleagues at the Edo Ministry of Health, and the Carter Center’s Edo/Delta project for their loss of a dear friend and formidable onchocerciasis warrior. *(Dr. Emmanuel Emukah, director of southeast programs in Nigeria, provided the preceding information.)*

Onchocerciasis-Associated Epileptic Seizures Debated in Journal

Carter Center epidemiologist Dr. Moses Katarbarwa and colleagues challenged the idea that onchocerciasis is a cause of epilepsy in a short report of a Ugandan study that appeared in the October 2008 issue of the American Journal of Tropical Medicine and Hygiene (AJTMH) (Katarbarwa et al., Could neurocysticercosis be the cause of onchocerciasis-associated epileptic seizures? 2008;78:400-1).

“If onchocerciasis were indeed the cause of epilepsy,” Dr. Katarbarwa wrote in his reply, “why does the condition persist as an incident condition in what are areas now under excellent [onchocerciasis] disease control?”

In 2005, The Carter Center-assisted river blindness program conducted a nodule prevalence survey in four onchocerciasis sentinel communities in Moyo district in northwest Uganda after 12 years of mass ivermectin treatment. Twenty-one nodules were excised, sectioned, and stained to assess for the presence and vitality of *O. volvulus* worms. The authors were surprised to find that seven (33.3 percent) of these nodules were in fact cysts of *Taenia solium*. A similar survey in Kanungu district in southwest Uganda revealed that four of six persons with “nodules” had subcutaneous cysticercosis. Cases of epileptic seizures were reported in some of the sentinel villag-

es and in other onchocerciasis-endemic communities of these districts.

The report provoked a lively exchange in the subsequent issue of AJTMH between Dr. Katarbarwa and Dr. Christoph Kaiser and colleagues (2008;79: 643-5). Dr. Kaiser argued that the onchocerciasis association with epilepsy was based on positive associative correlations from repeated studies over the past 15 years, many of



M. Katarbarwa

Ugandan schoolchildren greet onchocerciasis health workers who are surveying a river in an endemic area.

which were based not on nodule rates but on finding microfilariae in superficial skin biopsies (skin snips).

In his reply, Dr. Katarbarwa related an August 2008 trip he made with a Uganda district health team in a visit to a village in western Uganda where some 70 persons claiming to be epileptic came out in desperate hope of receiving medical assistance for their condition. This community has been under mass ivermectin treatment for

more than 10 years for onchocerciasis, with reported therapeutic treatment coverage exceeding 65 percent and skin snip data from sentinel communities showing very low microfilaria prevalence now in children as a result of annual ivermectin treatments (Katarbarwa et al, Trop Med Int Health 2008;13:1-8). Yet, in the village he visited, many of those persons suffering from epilepsy were children under 10 years of age, born after commencement of mass treatment for onchocerciasis.

“If onchocerciasis were indeed the cause of epilepsy,” Dr. Katarbarwa wrote

in his reply, “why does the condition persist as an incident condition in what are areas now under excellent [onchocerciasis] disease control?” The findings that epilepsy persists after onchocerciasis has been eliminated as a public health problem make the association more doubtful. All contesting authors agreed however that there was need

to recognize *T. solium* cysticercosis as a common and important public health problem that needs to be addressed in Africa. Relief should be provided to affected communities for this preventable condition.

Editor’s note: The International Task Force for Disease Eradication, meeting at The Carter Center in 1992, included Taeniasis/cysticercosis as one of the six potentially eradicable conditions on earth.

River Blindness

Sudan Program Review Addresses Elimination in Abu Hamad

The first northern sector Sudan River Blindness Program Review was held July 7, 2008, in Khartoum. Thirty-nine participants attended, representing all known endemic states and involved partners in the program, several Khartoum laboratories, and international universities (including Michigan State University and the University of South Florida). The Honorable Federal Minister of Health Dr. Tabita Shokai opened the meeting by conveying her appreciation for the reliable support provided by The Carter Center and the Lions Clubs to the federal Ministry of Health. A special guest was Dr. Sarah Carter, granddaughter of former U.S. President and Mrs. Jimmy Carter.

The meeting, supported by the Lions Clubs International Foundation/SightFirst (LCIF), was chaired by Dr. Kamal Hashim, the director of

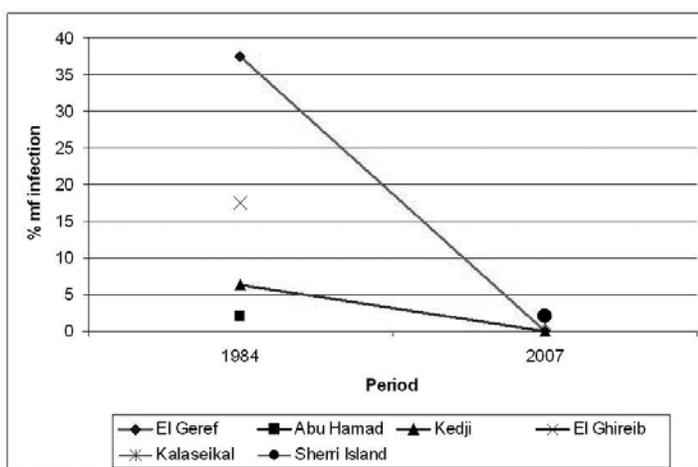
prevention of blindness in the Ministry of Health. Topics discussed included Mectizan® treatments and treatment coverage, health education and community involvement in the distribution process through the family/kinship system, and training and equipping personnel. Much discussion focused on the onchocerciasis elimination effort in Abu Hamad. In February 2006, The Carter Center/LCIF was asked by the Sudan government to join it in an onchocerciasis elimination program using semiannual treatments where the effort appeared to be technically feasible. Abu Hamad is the first target of this initiative. It was noted during the meeting that the Abu Hamad focus has made significant progress in reducing microfilaria prevalence compared to published baseline data from 1984,

indicating progress toward elimination of onchocerciasis there (see Figure 2).

A number of challenges were noted, such as increasing field activities to support twice-per-year treatments and establishing laboratory training for PCR and ELISA testing to clear the backlog of black fly and serum specimens. Such sensitive testing is needed to assess progress toward elimination. The construction of the Merowe dam poses a unique threat to Abu Hamad program activities. As this dam is completed, flooding and displacement of some endemic communities will complicate field work. These populations will be followed to their final settlement areas so that treatments can continue. The meeting resulted in key recommendations that will help the program in northern Sudan progress toward successful onchocerciasis control and, where feasible, elimination.

Figure 2

Decreasing Skin Snip Positivity in the Abu Hamad Elimination Effort in North Sudan



Program review attendees: (standing left to right) Craig Withers from Carter Center Atlanta; Dr. Nabil Aziz from Carter Center Sudan, Dr. Sarah Carter, Dr. El Khier Khalfalla from Lions Clubs, Dr. Frank Richards from Carter Center Atlanta, Drs. Tong Malek from Sudan Ministry of Health, Kamal Osman from Sudan Ministry of Health, and (front) Dr. Moses Katarwa from Carter Center Atlanta.

Trachoma

Trachoma

continued from page 1

holds. According to current World Health Organization (WHO) guidelines, active trachoma (measured as the prevalence of trachomatous inflammation follicular, TF, in 1- to 9-year-old children) is not a public health problem when TF is less than 5 percent. In this survey, the overall prevalence of TF was just 0.84 percent (95 percent confidence interval at 0.63–1.05 percent).

Active trachoma was reduced in all districts compared to the baseline surveys (see Figure 3). The overall prevalence of trichiasis (TT) in adults ages 15 years and older was 0.31 percent (95 percent confidence interval at 0.24–0.38 percent), which is below the 1.0 percent threshold, indicating active community surgical outreach is no longer needed. From this information, we can estimate that 4,950 people in Ghana have unoperated TT. Interestingly, the majority of TT patients are women (3,534) and men older than 60 years of age (3,594 cases), meaning that the program must determine how to reach this population of elderly women to provide surgery. Ghana has not achieved the ultimate intervention goal of fewer than one TT case in 1,000 persons and must demonstrate the capacity to identify and manage incident or recurrent cases through routine eye care services before certification of elimination can be attained.

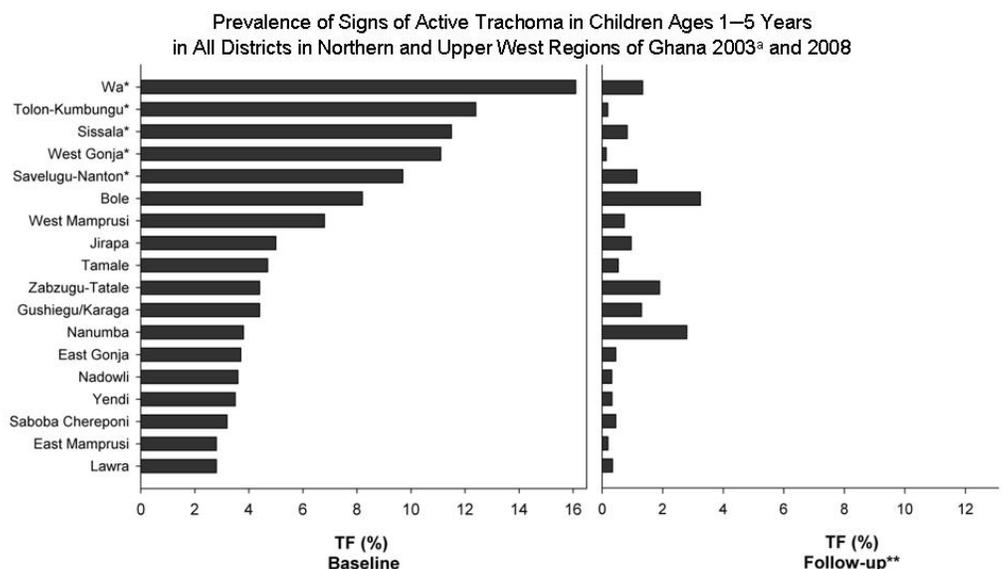
Ghana has successfully implemented activities to eliminate blinding trachoma in all endemic areas within the country and is thus a leading example in the WHO Global Alliance for the Elimination of Blinding Trachoma by the year 2020. Given the current low level of active trachoma, distribution of antibiotics is no longer necessary according to WHO guidelines, and the national Trachoma Control Program is planning to focus on sustainable health education and provision of surgery for incident and remaining TT cases.

The prevalence of trachoma in Ghana should be re-evaluated in three years, but the process for entering the phase of precertification for the elimination of blinding trachoma should begin now. The Ghana Health Service may well reach its target elimination

date by the year 2010, thus positioning Ghana to become the first sub-Saharan African nation to demonstrate that blinding trachoma can be eliminated through a multisectoral, collaborative partnership, supported by government, nongovernment, and private partners.

Ghana has successfully implemented activities to eliminate blinding trachoma in all endemic areas within the country and is thus a leading example in the WHO Global Alliance for the Elimination of Blinding Trachoma by the year 2020.

Figure 3



^a as reported by Ghana Health Service in the following unpublished documents: *Trachoma Prevalence Survey Results: Northern and Upper West Regions 2000*; and *Trachoma Prevalence Survey in Twelve Districts in Northern and Upper West Regions 2003*
^{*} Baseline data reported as TF and/or TI in children ages 1–9 years
^{**} TF prevalence at follow-up in 2008 corresponds with the age group reported in baseline surveys

Trachoma

First Ethiopian Maltra Week Mobilizes 13,000 Workers

Ethiopia President Girma Wolde Giorgis gave the first of a planned 5 million doses of the antibiotic azithromycin for trachoma control in Abaye Piccolo on Monday, Nov. 17, 2008, in the presence of the head of the Regional Health Bureau, Amhara regional state president, and local Lions, Carter Center, and International Trachoma Initiative staff. On the same morning, 13,000 health workers, volunteers, Carter Center staff, and Ethiopian Lions went to work throughout western Amhara, targeting the entire population of 135 districts, some 5 million people.

Nov. 17 kicked off “Maltra” week—the word a combination of malaria and trachoma—aimed at providing health

education on trachoma and malaria prevention, treating the eligible population with azithromycin, testing fever cases for malaria infection with rapid diagnostic tests, and treating those positive for malaria. Preliminary data on coverage are not yet available, but observations of activities made by Lion Teshome Gebre, Carter Center country representative; Paul Emerson, director of the Carter Center’s Trachoma Control Program; World Laureate Lion Tebebe Y. Berhan; and other Ethiopian Lions indicated that sensitization over the radio, use of a video van, and activities through the health service had reached practically everyone in the target area and that uptake of Maltra week activities was very high. “The phenomenal success of Maltra week is a testament to the power

P. Emerson (all photos)

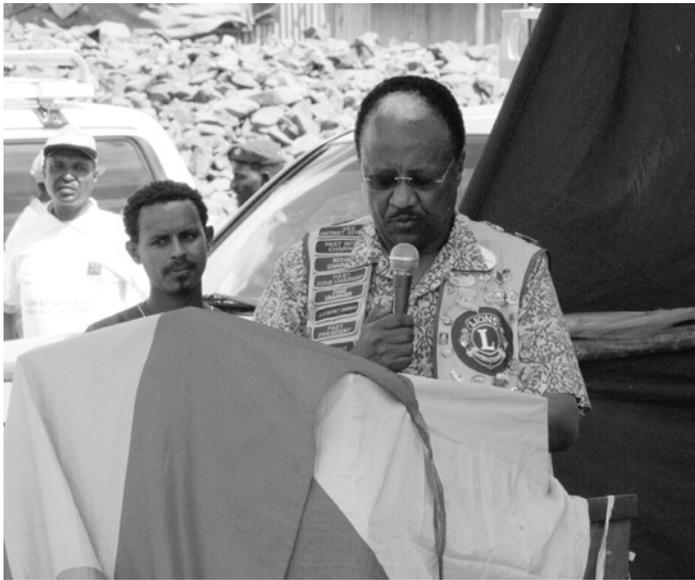


A health worker delivers a dose of azithromycin in western Amhara. An estimated 13,000 health workers and volunteers provided doses of the antibiotic during Maltra week.

Trachoma

of the Lions-Carter Center partnership and what can be achieved when we all work together,” said Tebebe.

In the previous year, a considerable amount of time was spent by the integrated malaria and trachoma program staff in Amhara on antibiotic and bed net distribution. The focus



World Laureate Lion Dr. Tebebe Y. Berhan addresses the crowd in Abaye Piccolo, Ethiopia, at the opening ceremony for Maltra week, an integrated malaria and trachoma awareness and treatment event.



Frew Demeke explains to community members how trachoma leads to blindness, helping them understand the benefits of taking azithromycin. Health education sessions also included malaria prevention. Community mobilization was conducted using a health education video van that traveled across western Amhara to visit villages and towns, encouraging the population to participate in the azithromycin distribution.

on this activity reduced available time for planning surgery campaigns, health education, and latrine promotion. To improve efficiency, it was decided that all the planned treatments (10 million per year) would be conducted in two massive campaign weeks held six months apart: one in the east of the state, the other in the west. The planned integrated malaria and trachoma weeks were welcomed by Minister of Health Dr. Tedros Adhanom Ghebreyesus and enthusiastically supported by the Regional Health Bureau.

More than 3,000 teams composed of a health extension worker or other health staff and three local volunteers were each equipped with measuring sticks, azithromycin tablets and suspension, rapid diagnostic tests for malaria, first-line treatment for malaria (with artemisinin combination therapy and chloroquine), census books, treatment guidelines, and health education materials. The teams worked on foot in and around their home villages, starting with health education and providing treatments from central places in their villages, then catching missing households through door-to-door visits.

The scale of the Maltra week achievement is not to be underestimated. During this first event, the Lions-Carter Center-supported program appears to have treated more individuals than the cumulative program output 2000–2006. This Maltra week demonstrates the capacity of an integrated program to deliver unprecedented levels of coverage in a short period of time.



A mother provides azithromycin to her daughter. With support from the Lions Clubs International Foundation and the Ethiopian Lions, The Carter Center distributed millions of doses of azithromycin in Maltra week last November.

Trachoma

Niger and Mali Programs Expand to Include Surgery, Antibiotics

Due to a generous grant from the Conrad N. Hilton Foundation, The Carter Center has begun to support all four aspects of the SAFE strategy in parts of Niger and Mali. Previously, the Center had focused on the facial cleanliness and environmental improvement (F&E) components of SAFE.

The national programs and their partners now have their eyes set on the elimination goal of 2015 and have comprehensive strategic plans in place to guide program planning.

Through the end of 2007, the F&E efforts had been highly successful, with more than 60,000 total household latrines built and more than 19,000 persons trained in health education in the two countries. The national programs, however, requested that The Carter Center and other partners provide additional technical and financial support for surgery and antibiotic distribution. The five-year Hilton grant and support from other donors will allow The Carter Center to respond to specific national program needs for mass antibiotic distribution and surgical interventions, while continuing health education and latrine promotion. Program expansion took effect Sept. 1, 2008.

To address mass antibiotic administration, The Carter Center is now supporting the purchase of tetracycline eye ointment to accompany the mass azithromycin distribution that is supported by the USAID Neglected

monitoring, and supervising trichiasis surgeons and enabling outreach surgical visits through the provision of motorcycles and fuel. Surgical strategy will include intervention at health facilities and surgical outreach camps.

While additional partners are still needed to meet the elimination targets for Niger and Mali, this boost of support from the Hilton Foundation allows the Carter Center's Trachoma Control



A group of newly trained trichiasis surgeons is certified by the national trachoma program in Mali with Carter Center support.

Tropical Disease Initiative. The Center is directly supporting areas ineligible for USAID support. This comprehensive support of antibiotic distribution by several partners will ensure that all target regions receive treatments.

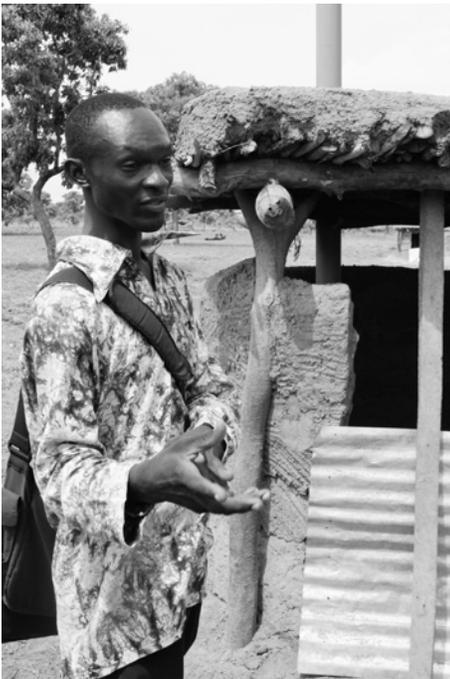
Surgical interventions in both countries will focus on increasing the number of trained trichiasis surgeons and on making available all consumable materials and equipment. The Carter Center is supporting the national programs in training, certifying,

Program to be flexible in supporting a variety of national program priorities and allows increased support of latrine promotion and health education. Five-year planning workshops took place in November 2008 in both countries, which mobilized trachoma-endemic regions and local and international partners. The national programs and their partners now have their eyes set on the elimination goal of 2015 and have comprehensive strategic plans in place to guide program planning.

Trachoma

Series on the Human Face of Trachoma Control Ghana Field Officers Bring Lasting Change to Communities

Carter Center support to the Ghana Trachoma Control Program has focused on the promotion of household latrines and on health education. Carter Center field officers in Ghana play a major role in implementing and monitoring these activities and in strengthening partnerships with endemic communities and with the Ghana Health Service. They are found most often in the field



Joseph Maal-Ire Tang (left) and Yakubu Yussif (right) inspect the construction of new household latrines.

on their motorbikes, working hand in hand with trachoma-endemic communities and ensuring work is completed properly and efficiently. The following narrative is based on the routines of three Carter Center field officers:

Nazeed Fusheini, Yakubu Yussif, and Joseph Maal-Ire Tang.

“A typical day for me begins on my motorcycle, riding out to a community where I’ve been helping build pit latrines. I like to arrive early, before the men and women have left for the fields to begin harvesting their crops. I meet with the trained latrine mason, follow up on the cement storage, and



L. Rotondo (all photos)

determine how much cement and other latrine supplies have been used. I also visit with the village chief, asking about community members who are having trouble with the physical labor of building the superstructure. With the chief and community leaders, we

find a way for the community youth to help elderly and disabled people build their latrines. Together we visit all the newly constructed latrines and pay close attention to households that have not yet begun construction. We gather the community to talk about solutions to ensuring every household has a latrine.

Sometimes I like to stop by the community primary school with my health education flip chart. We’ve trained the schoolteachers in trachoma education, but sometimes the children pay closer attention when a visitor comes to the classroom. I talk to the children about their new family latrines, asking them whether they prefer using a latrine over going to the bush. The girls are particularly happy to have the privacy of a pit latrine at home. The children are quite proud to talk about their new latrines, noting how their father dug the latrine pit and their mother and sister fetched water and riverbed sand for the slab construction. I also talk to them about the importance of keeping their hands and faces clean to keep trachoma away.

On my way back to town, I might stop at the local government district assembly office. The district assembly chairperson provides leadership to the latrine promotion project. The larger quantities of cement and other materials are kept in the district assembly storage room, and supplies are often distributed to me. My job has been much easier thanks to the partnership I have with the district assembly.

I’d say my favorite part of the day is when I visit a community where latrines were previously completely unknown, but where there is now total sanitation coverage. When I first

continues on page 12

Trachoma

Ghana

continued from page 11

visited these communities, the citizens did not know about latrines and did not care to find out. After our health education efforts and local partnerships, we worked together to build latrines for every single household, and now there is no turning back. The women and children say they would never return to their old ways, and the men are proud of their work. I feel pretty confident that my work in these communities will have a long-lasting impact, far beyond elimination of blinding trachoma.”

This is the ninth 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



Nazeed Fusheini educates schoolchildren on the importance of washing their faces and hands.

depicted. Carter Center trachoma activities in Ghana are supported by a generous grant from the Hilton Foundation.

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