Implementation of the Full SAFE Strategy," the participants discussed best practices for trachoma control in the context of integrated neglected

Trachoma

Trachoma Review

continued from page 1

interventions targeting trachoma and Guinea worm disease in Southern Sudan.

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Figure 1

Program Participants

National trachoma control programs were represented at the program review by Dr. Oscar Debrah, Ghana; Dr. Kadri Boubacar, Niger; Dr. Bamani Sanoan /MCEMC /CS0 CS 1 SCN0.5 w 33DC

Trachoma

Trachoma, Schistosomiasis Assessments Combined in Two Nigerian States

District-level estimates of prevalence are recommended for mapping trachoma prior to intervention. Where the prevalence of active trachoma (trachomatous inflammation—follicular TF) is 5 to 9 percent in children ages 1 to 9 years, a community-by-community approach to assessment and intervention is suggested. Yet there is no recommended methodology for assessing trachoma at the community level. One option for mapping urinary schistosomiasis, caused by the parasite *Schistosoma haematobium*, is the rapid assessment of blood in the urine (hematuria) in schoolchildren to provide a community estimate of the burden of the disease. Decisions about drug interventions to control schistosomiasis are made at the community level based on these estimates in schoolchildren.

In Nigeria, The Carter Center and the ministries of health of Plateau and Nasarawa states conducted integrated surveys to map trachoma and urinary schistosomiasis in eight local government areas (LGAs) of the two states to determine whether the integrated results provide sufficient evidence to guide program interventions. In the first survey, trachoma assessment was added to the World Health Organization (WHO)-recommended methodology for urinary schistosomiasis mapping. All rural government primary schools in the LGAs were surveyed by taking a systematic sample of children for each disease. All children younger than age 10 years were eligible for a trachoma exam. All children ages 10 to 14 years were eligible for hematuria assessment with a dipstick test.

The second survey added indicators for urinary schistosomiasis, lymphatic filariasis, and household characteristics like mosquito net ownership to the recommended trachoma survey methodology. A systematic sample of 20 enumeration areas (EA) per LGA served as the primary sampling units. Households in each EA were randomly selected with equal probability. People of all ages were examined for trachoma, and children ages 10 to 14 years were selected for hematuria assessment.

According to WHO guidelines, the findings indicated that district-wide trachoma interventions were not needed for any of the LGAs surveyed. School-based and cluster surveys gave similar district-level estimates for TF, although trichiasis prevalence could not be derived with school-based methodology. LGA-level estimates of hematuria from cluster surveys were unable to identify communities that warranted

Surgery a ‘Second Birth’ for Mother

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River Blindness

River Blindness Review

continued from page 1

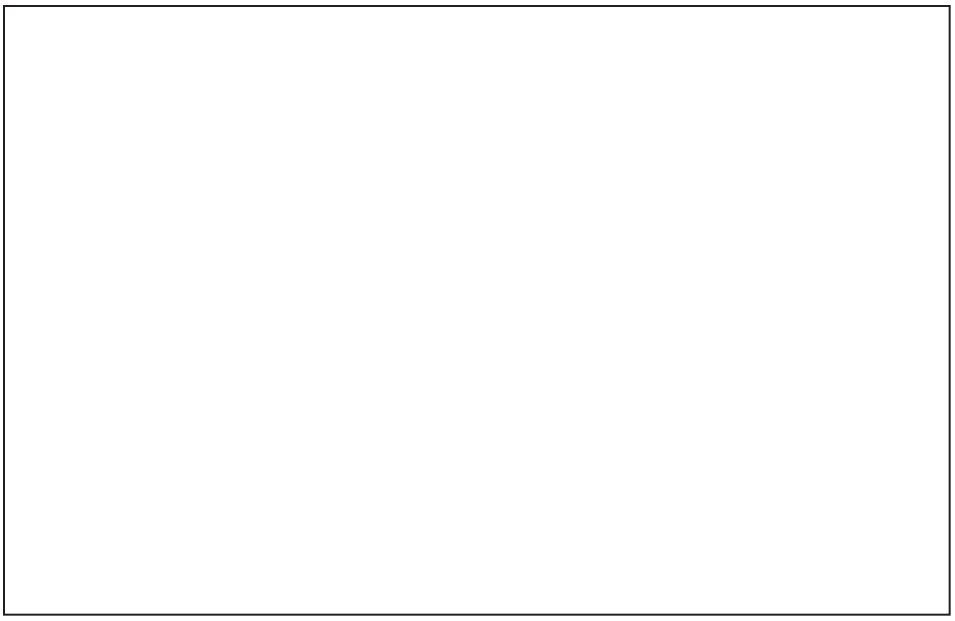
in 2007. Except for Uganda (1,954,178 treatments), all countries were assisted under the Lions–Carter Center SightFirst Initiative, often with the active participation of local Lions.

Participants included Carter Center staff, representatives from ministries of health of Uganda, Cameroon, Nigeria, Sudan, and Ethiopia, and representatives from the Onchocerciasis Elimination Program for the Americas (OEPA), Lions Clubs International Foundation, Merck and the Mectizan® Donation Program, the African Program for Onchocerciasis Control, the Izumi Foundation, the U.S. Centers for Disease Control and Prevention, and the Bill and Melinda Gates Foundation. Guest speakers discussed topics ranging from a study on the costs and savings associated with integrating health programs to a recently published report of alleged Mectizan resistance in Ghana. In addition, activities to integrate river blindness control with lymphatic filariasis elimination, schistosomiasis control, malaria control, and vitamin A distribution were reviewed. Dr. Frank Richards, director of the Carter Center's malaria, river blindness, lymphatic filariasis, and schistosomiasis programs, chaired the meeting.

Figure 5

One of the important goals of the River Blindness Program is to eliminate onchocerciasis where and when possible. In areas where elimination is deemed possible, Mectizan treatment is used more intensively—every six months—so that transmission can be interrupted. The goal in these cases is that Mectizan distribution can eventually be halted when evidence shows that the parasite population has disappeared. For areas where elimination currently is not possible, sustainability and integration of programs are vital for Mectizan treatment to continue indefinitely. In the areas where the River Blindness Program is working to eliminate river blindness, which includes six countries in Latin America plus areas in Sudan and Uganda, the Center assisted in 2.13 million treatments given semiannually. The majority of assisted treatments, 10.86 million, were given annually in Nigeria, Cameroon, Ethiopia, and nonelimination areas of Uganda and Sudan.

Table 1



River Blindness

In November 2007, The Carter Center celebrated the 100 millionth assisted Mectizan® treatments for onchocerciasis since the Center's River Blindness Program launched in 1996. The treatments

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