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People and organizations

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People and organizations

WHAT IS THE ROLE OF "MOTHER AND CHILD" IN THE TRANSMISSION OF TRACHOMA? HOW CAN WE REDUCE OR PREVENT THIS WAY OF CONTAMINATION?

Although the effects of trachoma have been known for thousands of years, the ways of direct transmission of trachoma from one person to another are still not perfectly understood. Moreover, there is indirect contamination through contaminated objects such as towels, handkerchiefs, clothing, and the mother's "shawl", which is used for blowing the nose, and wiping the eyes and face of the child.

Children are the classic "reservoir" of *Chlamydia trachomatis*. However, in general, it is not enough to only treat the children for the infection to disappear from a community.

Any person looking after a child carrying active trachoma risks being infected. Thus women, because of the constant care that they lavish on children, are most at risk from reinfection, and evolution into trichiasis and blindness.

Mother and child, seemingly inseparable (the mother with the child on her back in West Africa), therefore are the first to have attracted the attention of epidemiologists. In this "couple", the risk of contamination goes in both directions.

In Mali, children raised by women with active trachoma are more at the risk of contracting trachoma. The prevalence of trachoma in children increases with the age of the mother, perhaps also with the size of the family. Moreover, mothers of children infected by trachoma are more frequently infected than those whose children do not have trachoma or those who do not look after children.

However, the identification of the mother and child, in the strict sense, as the pivot of transmission appears too restrictive. In West Africa, apart from the breast-feeding period, the mother is not the only person to look

after the child. Young women are frequently responsible for many domestic or agricultural tasks, and other women look after children: elder sisters or grandmothers, who may be infected, then in turn become infectious carriers. In fact, a mother often has little contact with her child during a good part of the day, except for breast-feeding times. It is only during the night that children are very close to their mother. Children already weaned are constantly under the protection of the grandmother.

The people who look after the child while the mother works can infect this child or be infected by him, as the child can be by his mother or conversely.

Considering the social organization of many African communities, it is thus essential to pass the message concerning the war on trachoma to all those coming into contact with the child.

Conclusions and recommendations

The mother has an intimate contact with her child, but many other women may play a role in the transmission of trachoma, especially older sisters and grandmothers. All must be targeted by the IEC campaigns to change hygiene practices.

The school can play a role in informing older sisters when they attend it. Elderly women can receive advice through women's associations.

The messages concern the need to use a clean cloth to wipe the child, to wash the hands after certain care, and to remove the feces of children from the house yard and the immediate neighborhood of the house. This disposal is far from being foreign to the codes of civility of many villagers.

HOW CAN WE MOBILIZE SOCIETY, ESPECIALLY WOMEN, IN THE WAR ON TRACHOMA?

The status of women varies considerably between cultures in the African continent, but in most West African societies, women, traditional guardians of the home, play a prominent role in everything concerning the education of children.

They are involved in most sanitation activities: sweeping the hut, washing children, washing clothing and kitchen utensils. They transmit the codes

of conduct concerning cleanliness to children, codes that have many moral and sexual connotations. Everywhere in West Africa, it is young girls and women of childbearing age who mainly carry out the water chores, who manage the use and allocation of water to the various points, with priority to the kitchen. Water reserved for washing may be less than two liters, or even none.

It is the head of the family who decides and supervises the construction of latrines, but it is the mother who manages daily cleanliness and maintenance. Failing which, the positive effects of the sanitary arrangements are quickly cancelled.

The promotion of cleanliness and hygiene must take into account women's constraints and codes of conduct. It is not only a question of elementary respect for women's rights, but quite simply ensuring the long-term viability of the projected measures.

Mobilization and awareness can take different forms depending on the context: countryside and village, and region.

The role of women in the domestic and village organization has been the subject of many studies. There is a long-lasting asymmetry in the education of girls and boys, which is far from being corrected by the existing school systems. The participation of girls in domestic work limits their spare time and often separates them from the school. The inequality of access to schools between boys and girls is even more marked in rural environments.

Traditionally, women do not participate in village councils making important decisions. On the other hand, functional organizations, such as committees responsible for water projects or the health committees, accept women more easily. In this way, they take part in discussions and local decisions. Women invest themselves perhaps more readily in duties without financial reward, accustomed as they are to voluntary work.

Some of their independence comes from their commercial practices. Their financial power is increasing, but the weight of prejudice and tradition, which limit their voice in the village environment will only decrease gradually. Many NGOs have chosen women as beneficiaries of micro-financing projects. In Pakistan, for example, programs of environmental sanitation have given them greater financial independence. The advent of women's

groups is upsetting tradition and strengthening their negotiating power in areas such as water, traditionally their domain. In cities, some associations are headed by women managers or women with policy responsibilities. They can mobilize real lobbies to make people around them aware of the need to combat trachoma and blindness, and involve female associations in rural areas.

In many West African societies, elderly women (mothers, aunts or mothers-in-law of the husband) form a real united group intervening in the health of the family. They have more time because they are generally released from the most tiring domestic chores. Considering their influence over the young mothers, it seems wise to encourage organizations of elderly women. As regards disabilities, which they know well and fear, they can in their turn encourage people affected by trichiasis to seek suitable treatment from the health services.

Conclusions and recommendations

Hygiene is women's responsibility. They often take part in village committees, or provide information about health, behavior and sanitation. Economic or financial micro-projects that give women responsibility and some financial independence can also be the opportunity for making them aware of the problems of hygiene and the environment, which play a role in trachoma.

CAN THE COMPONENTS OF THE SAFE STRATEGY BE INTEGRATED IN THE HEALTH SYSTEM AND DEVELOPMENT PROSPECTS?

The answer to this question is very important. Indeed, the SAFE strategy involves a new way of working, both for the ministerial management concerned (the coordination of numerous activities is essential) and the communities (its implementation requires good communication with the populations).

Trachoma control in Africa and especially in Mali

Even if it is not at the head of the list, trachoma is one of the priorities of the ministry of health in the republic of Mali. Since its foundation in 1953,

IOTA, with a regional vocation, has given a major place to combating trachoma in medical programs in Mali. The training of several dozen nurses specializing in ophthalmology has provided a better way of treating eye infections, and therefore trachoma, in practically all regions.

In the seventies, trachoma control relied on the methods recommended at the time: the systematic application of tetracycline ophthalmic ointment for six days a month for six months, operating on trichiasis, and health education programs to improve personal hygiene, are three components of the SAFE strategy, which has benefited from a lot of support from the YELEEN program for combating blindness. Its mobile teams traveled through the rural regions to identify operable carriers of diseases (cataract, trichiasis) and direct them towards the hospitals where the operations were performed. Spectacular results were obtained in ten years, thanks to an unprecedented mobilization of material, human and financial resources. The end of international credit meant that it was not possible to organize a real continuation of this ambitious program and its integration in the country's health system. Not all the other Sahelian countries have such active antecedents as regards combating blindness (apart from the OCP programs, the Onchocerciasis Control Program in West Africa). Nor do they have training centers specializing in ophthalmology like IOTA.

Current mobilization and the decentralization reform

The Malian government's present level of priority given to trachoma does not only result from its strong prevalence, its effects on public health and its economic and social consequences. It represents a deliberate political decision, faced with the prospects offered by the SAFE strategy in 1997. It is a new model as regards medical action against trachoma, insofar as it takes into account all the factors that generally determine the health of the population (hygiene, health care, environment, behavior). This strategy recognizes the absence of one single measure capable of eliminating trachoma, and necessarily is interested in many sectors and all decision levels, from ministries to communities.

Including components of the SAFE strategy in the Malian health system offers a model that could be appropriate for other West African countries concerned about trachoma.

Adopting the SAFE strategy in Mali coincides with a reform aimed at decentralization, which confers a major role on the communities¹². The role of the State, in the spirit of this reform, is to inform all the communities in areas of endemic disease of the possibility of fighting blindness and trachoma, and to specify the methods of control. It provides them with the necessary technical and financial resources. The community is responsible for basic education, promoting hygiene, village water systems and first level medical action. It is thus theoretically the most capable «operator» for effectively combating diseases. It receives the mission from the State and accepts this role through a formal contract.

However, since their creation, the communities have had difficulty in identifying their role and organizing their health activities; they have left the finite field of combating transmissible diseases to enter that of development.

Required by law (the local communities code) to promote medical action in their districts, local councils need to discover their role and acquire operational methods. Trachoma control can be an opportunity for mobilizing the communities. With the involvement of the most qualified people in the village, they need to prepare an integrated medical action plan, which includes a medical program, a school health program, a hygiene program and an IEC program.

In future, apart from knowledge about trachoma control alone, this experience should allow communities to undertake other medical programs in the same spirit of varied skills, participation and contract-based solutions.

Hence, the idea that the campaign against blindness (and trachoma) could be usefully presented by the government to mayors, during their national association general meeting. The communities should discuss a program identifying activities to be organized locally, and submit a contract proposal for objectives and resources to the national ministry of health.

How can the campaign be deployed in the community?

Preventive action

The purpose of this action is to combat the infection of unaffected persons and the reinfection of the infected persons.

¹² This reform is also being developed in other Sahelian countries. Many issues depend on its practical implementation.

In Mali, where the literacy rate is still low, the Information-Education-Communication (IEC) program is an essential undertaking. The national information program, founded on the preliminary work of a team of communication specialists, aims at making people aware of the causes of blindness, one of which is trachoma, and encouraging all those that suffer from vision problems or ocular pains to go to the center health in their district. It calls for the production of educational films for television, and radio programs for the many local radio stations, adapted to the culture and languages spoken in the country; also for the publication of brochures and posters in the national languages and French.

The messages concerning trachoma cover a much wider field. Childhood illnesses associated with the lack of hygiene, among others diarrhea and skin diseases, can be included in a common IEC "package". Trachoma can be one of the doors to an ambitious health education program.

Television reaches enough people to exert an influence. About half the Malian population has access to television. Rare are the villages that do not have at least one television set. However, it is still necessary to evaluate the impact of broadcasts concerning health.

The creation of groups of actors to present educational sketches in the villages or districts, following the "koteba" model, is a means to be explored. The TRACT association, which endeavors to promote "practical theater", has proved that visits to schools and villages help to disseminate knowledge and change behavior.

Water system and sanitation measures help in economic development and improving the life of the population. They are thus part of a very wide agenda where several administrations and many development organizations are involved. Trachoma control is a strong argument for mobilizing resources and getting the people involved to work together.

Medico-surgical action

These take place at several levels, locally (health center), regionally and nationally. The local level is where the components of the SAFE strategy should be integrated in the health system in the most tangible way.

Whether the peripheral health center is public, community, belonging to a particular or private organization, the medical team can carry out two types of action.

Mobile action

“Advanced” health action in the village needs one or more members of the medical team to travel to the health center, either periodically or in response to a need not programmed.

The periodic action of the team begins with a census of the population benefiting from vaccination, family planning, hygiene education programs, targeted examinations (children under 5, pregnant or breastfeeding women), examinations and treatment of any sick person, and distribution of medicines such as vitamin A. The distribution of antibiotics enters into this work.

It is essential for health workers to be rewarded on results. The daily allowances must only cover expenses concerned with travel (accommodation and food), but there must be a system of bonuses linked to the effective accomplishment of the contract agreed by the community and the State.

Treatment for trichiasis is also part of an “advanced” strategy. Any person with an operable trichiasis should benefit from surgery. The screening of people suffering from this affliction is also the occasion for identifying cataracts and sending these people to the place where this surgery is practiced. Surgery for trichiasis thus fits perfectly well with all ocular treatment aiming at preventing or curing blindness.

Fixed action

Apart from the programmed campaigns against trachoma, the diagnosis and treatment of people presenting inflammatory trachoma have their place in the treatment centers. During antenatal, postnatal or family planning consultations, mothers and children under 5 years of age should automatically receive an ocular examination with inversion of the eyelids for diagnostic and therapeutic reasons. All systematic visits should be an opportunity for examining the eyes.

Here also, the school can still play a role by systematic examinations of pupils to look for signs of trachoma. The treatment is provided from the school medical cabinet, with which each school is normally equipped, or from the health center.

The organization for trachoma control

At the level of the districts themselves, trachoma control is directed by the head doctor of the district, aided by a medico-technical team, who provides a supportive and administrative role for the communities.

Regionally, the regional ministry of health coordinates and monitors trachoma control. The actual ophthalmologic aspects are entrusted to the ophthalmologist doctor of the regional hospital, who devotes part of his time to combating blindness in his area.

Centrally, the national trachoma control program is part of the national program for combating blindness. In Mali, IOTA brings its technical skills to the whole program, especially through evaluation, staff training and research.

Training, essential for decentralization

The skill of the health worker as regards trachoma is the key to the program.

Training has always occupied a major place in the IOTA courses. The doctors and nurses who have benefited from it have acquired unquestionable skill. However, training for action in the field, the anthropology of health or communication have, up to now, not been sufficiently taken into account.

Training is given at the various administrative levels of the health system, with an emphasis on listening and dialogue.

To avoid too many training courses, which complicate and disorganize planning, visits by senior staff could also be the occasion for training or "on-site" refresher courses.

Conclusions and recommendations

The medico-surgical action can be integrated in the existing health system, whatever the method of dispensing the antibiotics. However, it involves additional work, which may be considerable, and must not detract health workers from their many routine tasks. The watchword could be to integrate the concern for trachoma and its blinding consequences in the daily activities and to speak about trachoma each time the opportunity arises. The support of the various NGOs active in the field of trachoma is valuable if they work with, and under the coordination of, a national program and those responsible for the campaign against blindness, which differs a lot between regions.

The State alone may decide whether to firstly consolidate the campaign against blindness in the regions where it has been launched or, without awaiting perfection, to extend the operations to the provinces, which are dissimilar by definition; thereby learning from the different experiences and human resources progressively as the plan unfolds.

EXPERIENCE OF THE SAFE STRATEGY AND ADOPTION BY THE COMMUNITY

As we have seen, the application of the SAFE strategy with all its components has unquestionably given excellent results in combating trachoma, especially in Morocco. However, it has to be emphasized that in all cases, it is not strictly correct to speak of "adoption by the communities", insofar as they are public health measures impelled from above that have improved the environment, made sufficient quantities of drinking water available, and set up systems for removing and treating refuse. In this respect, trachoma control has no particular distinctive features. Controlling diseases such as tuberculosis or diarrheal illnesses in the industrialized world was done thanks to statutory regulations, which helped to improve living conditions (eliminating unhealthy residences and improving food quantitatively and qualitatively). It is difficult to prove that the communities have completely adopted all the measures applied. Changes in behavior have resulted from the convergence of information, probably digested over time, and measures sometimes frankly coercive. However, the populations are shrewd observers of the results of the State's action in the field, and learn the lesson from the events.

We have relatively little information about the way in which the communities have reacted to the measures applied. Information has been disseminated in a language accessible to the population. Measures transforming the environment have increased the wellbeing of the villagers, creating an atmosphere receptive to change. Literacy courses (and "post-literacy courses") have been followed by help with personal education and finding employment, without which the skills acquired would quickly disappear. Village committees have been created and perpetuated in the form of associations. Public debates have been organized to interest the communities in the question of trachoma, resulting in some installations being taken over.

Conclusions and recommendations

In the context of decentralization, the Malian experience has provided a unique opportunity for testing the community's commitment to health and its ability to adopt measures initially launched by the State as part of the national program for combating blindness. Adoption by the community is incontestably an essential factor in the success of this program and trachoma control. However, the role of the State must not be neglected.