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World Health Organization

Prevention of Blindness and Deafness

Report of the Ninth Meeting of the WHO Alliance for the Global Elimination of Blinding Trachoma

Geneva 21–23 March, 2005

GET 2020

GLOBAL ELIMINATION OF BLINDING TRACHOMA BY THE YEAR 2020

ACKNOWLEDGEMENTS

The World Health Organization gratefully acknowledges the support given to the WHO Alliance for the Global Elimination of Blinding Trachoma by its many partners. Among those activities, the annual meeting of the members of the Alliance is a vital opportunity for sharing of information and experience, as well as articulating the immediate challenges and reaffirming the group's commitment to achieving the ultimate goal of elimination. Thanks are extended not only for the financial support that enables the work of the Alliance, but for the work done during the meeting itself and in the preparation of the report.

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1. INTRODUCTION

The ninth annual meeting of the WHO Alliance for the Global Elimination of Blinding Trachoma by the Year 2020 (GET 2020) was held at the headquarters of the World Health Organization, Geneva, from 21 to 23 March 2005. The meeting was attended by 31 national coordinators; 14 representatives of WHO collaborating centres for the prevention of blindness, and other research institutions; 14 representatives of nongovernmental organizations and foundations; 6 observers; and 13 technical staff from WHO, including a representative from the Regional Office for Europe.

Dr Serge Resnikoff, Coordinator of communicable disease control and management opened the meeting, welcoming all participants on behalf of the Director-General of WHO and recognizing the value of so many interested parties coming together to exchange information under the new, refocused presentation format. International cooperation and community development — both key components of successful programmes — were developing strongly. The significance of blinding trachoma elimination went beyond communicable disease control; as a disease of poor, neglected, underserved populations it was related to wide societal and environmental issues that must remain central in discussions. The framework for the certification of elimination had been given formal approval and WHO was now working to develop the process for those countries that were ready to be certified.

Dr Silvio Paolo Mariotti, meeting coordinator, outlined the new reporting format under which country presentations would be made. This reflected the wishes of the Alliance, expressed at the eighth meeting, to reduce the number of presentations, standardize and condense the material presented, and thus maximize the time available for discussion. Accordingly, (in principle) data sheets were received in advance of the meeting, and only the relevant problems, challenges, solutions and opportunities taken were to be reviewed, for selected countries. The Alliance had also expressed the view that countries with large populations should give updates on progress every year, and accordingly reviews would also be presented by Brazil, China and Nigeria.

Dr Grace E.B. Saguti (United Republic of Tanzania) was elected Chair of the meeting, with Ms Dyanne Hayes (Conrad N. Hilton Foundation) as Vice-Chair. Professor Nouhou Konkouré Diallo (Guinea Conakry) and Dr Rajiv Bhalchandra Khandekar (Eye and Ear Health Care, Ministry of Health, Sultanate of Oman) were elected Rapporteurs.

The Agenda was adopted, with modification to the list of countries presenting on the second day and inclusions of various update briefings (Annex 1). The list of participants is contained in (Annex 2).

In May 2005, the International Organization Against Trachoma will award Dr K. Konyama the Trachoma Gold Medal, and he will deliver a keynote address on trachoma control in Asian countries and its essential integration into primary health care.

2. COUNTRY REPORTS

2.1 United Republic of Tanzania (Dr Grace Saguti)

Challenges, opportunities and lessons learnt in upscaling the trachoma control programme in Tanzania

Trachoma control was started in the 1970s by nongovernmental organizations (NGOs) working in specific disease-endemic areas, especially in the centre of the country. Control activities were enhanced in 1988 by the formation of the National Prevention of Blindness Committee, and again in 1999 through the public-private partnership with the International Trachoma Initiative (ITI). With ITI, implementation began of the WHO SAFE strategy and Zithromax donated by Pfizer began to be used in six districts. In 2003, the SAFE strategy was integrated into the district health system, enabling the control programme to expand by 10 districts annually (reaching 30 districts in 2004). The five-year National Trachoma Control Programme (NTCP) was established in 2003, with a strategic plan prepared in 2004 and a baseline survey organized.

Currently, it is estimated that trachoma is endemic in 50 districts (out of 119 districts in the country). Initial survey data have been gathered from 30 districts (together with outreach data). There are 12 million people at risk; 2 million children below the age of 10 years have active disease. The TT backlog is estimated at 54 000. Approximately 45000 people have been blinded by trachoma.

Regular reporting on all eye-care diseases at regional and district level provided the data on the basis of which the first 30 districts were chosen. Of the initial districts surveyed, 26 have more than 10% active trachoma. Only four districts have less than 4% active disease, in focal areas. Contrary to expectations, preliminary mapping shows the incidence of TT as varying throughout the country. It is expected that the remaining 20 districts will be surveyed in 2005, completing the study.

There are many challenges facing the programme, such as a lack of adequate human resources and sufficient capacity to implement the SAFE programme. The baseline survey revealed an increase in the population to whom azithromycin would need to be distributed (from 1.5 million to 7 million) following the programme strategy of mass administration at district level. To accomplish this strategy, the programme has had to find ways of motivating the community distributors, linking with other programmes such as lymphatic filariasis and onchocerciasis control. Advocacy has been vital in convincing districts of the need to allocate resources to trachoma control in the face of competing demands from "killer diseases" such as malaria, HIV or tuberculosis. This is especially critical in influencing decisions on the budget ceilings for disease elimination. There are challenges to enhancing community "ownership" of the blindness prevention programme, and to increasing its integration with other programmes. The "F" and "E" components of the SAFE strategy have progressed very slowly, despite efforts to involve the community in a participatory approach. Although all elements of the SAFE strategy are implemented in all districts under the programme, latrines have been built in only six districts under this participatory initiative. The political environment has not been favourable to the programme, which has been interrupted by elections at local and presidential levels. Furthermore, where districts have fallen below the "10% threshold", there is a challenge to establish surveillance at village level.

Opportunities related to these challenges include the prospect of incorporating trachoma plans into the poverty reduction policies. The elimination of blinding trachoma needs to be given a higher priority, and community ownership increased.

Among the lessons learnt are that advocacy has generally raised the level of awareness of trachoma as a public health problem. In 2004, on World Sight Day, the Vice-President's office was the guest of honour, with strong emphasis on "F" and "E" in trachoma control through the involvement of the ministries of environment and water. The SAFE strategy is the best approach for trachoma control, especially when well managed at grass-roots level. The "S" and "A" components are easily implemented in the health sector, with azithromycin being well accepted in the population. As a broad-spectrum antibiotic the drug has an effect on more

than just trachoma. In order to reduce costs, community-level implementation can be strengthened. Regional level skills need enhancement to provide appropriate technical support with support in finance and programme management particularly needed.

Discussion

Human resources: The issues of affording and training sufficient human resources is one common to many countries. In Tanzania it is a major focus for the National Eye Care Strategic Plan, where mid-level workers, such as assistant medical officers and nurses are receiving training to become "integrated eye nurses" in preference to the lengthier training for ophthalmologists. Policy guidelines in eye care (under review by the Government) will direct districts how to pick and train people who will stay in the districts to implement the programme. Selection will be supported by a committee that will also give advice.

Community distributors: Motivation of community distributors can be problematic given the several competing demands for attention and resources. In Tanzania the first step is to understand the health problems experienced by the community, such as malaria, or HIV, and then to fit prevention of blindness into that picture, using educational tools to illustrate the interlinkages. Incentives for distributors relate to the good of the community rather than to financial gain as an employee. If there is already a distributor for another programme, that person should also be used for the trachoma work. Decisions such as the mode of distribution — whether house-to-house, or from a central point — are made by the community itself, supported by technical advice from experts.

There are no centralized national criteria for selection of distributors and community representatives. This is done by the districts themselves, selecting people who will stay in the area after training. In districts that do not yet implement the SAFE strategy, treatment of trachoma remains a priority under the national eye-care programme, with surgeries conducted and antibiotic treatment with tetracycline.

Political environment: Although political change can be distracting, especially at ministerial level, the mechanisms of implementation and the advocacy activities continue via the many levels of technical staff in the ministry which remain despite changes at the top management level.

Research: Research is being conducted, in one district, on re-emergence of trachoma after mass treatment. The results of this study are not yet available.

Integration/partnership: Excellent partnership has been achieved through joint work in the National Trachoma Control Taskforce at which all ministries are represented, at both regional and district levels. When members of ministries such as education, sanitation, water and environment attend taskforce meetings, they then share that information with their own ministries. Integration is thus achieved right down to district level.

Among the many partners working in Tanzania, World Vision, in conjunction with the Conrad N. Hilton Foundation and the Carter Centre, has supported trachoma control, with emphasis on the "F" and "E" components of the SAFE strategy, constructing a number of wells and providing water to communities in the centre of the country.

Rather than trying to educate communities programme by programme, the question was raised of integrating public health education and strategies on communicable and noncommunicable diseases for district health services.

Those health services must also have a sense of ownership of programmes if they are to be sustainable. In Tanzania, all education efforts are coordinated through the district health management team, which achieves integration, although some districts need much support and motivation to make this work and progress is slow in the system as a whole. Attempts are being made globally to integrate vertical programmes, combining activities that target similar age groups etc.

Lessons learnt: Three important elements for other country programmes to note would be: a focus on education for the young, to teach the next generations how to prevent the disease; an emphasis in districts on providing safe and permanent structures for water near communities; and strengthening the health services to deal with those who already have the disease.

Lessons have been learnt about mass drug administration from the onchocerciasis programme: in a pilot project observed by five other districts, eye-care personnel drew on their observations of ivermectin distribution for azithromycin mass distribution.

Surveys: WHO guidelines indicate that all districts over the 10% threshold must have mass distribution of azithromycin. Where the district has less than 10% active disease, Tanzania will re-survey the communities to identify treatment needs so that villages without endemic trachoma do not receive unnecessary treatment.

Scaling up TT surgery: Given the human resources deficiencies mentioned, scaling-up the surgical component of the strategy remains a challenge. Guidelines have been prepared on the Bilamellar Tarsal Rotation (BTR) procedure, as recommended by WHO, and given to all surgeons in all districts. Tanzania has decentralized surgery for trachomatous trichiasis (TT) to the district level. In all communities, a health worker keeps a register of cases identified (through screening) for surgery, showing the burden of TT cases. This information provides the basis for planning of training and surgery by the district eye-care coordinator. There are three training centres, teaching six trainees per quarterly session.

Coordination of resources: Ways of best using the resources of the NGOs were discussed, and acknowledgment given of the contribution made by many partners in the field. There are annual forums in which NGOs meet as a group to discuss plans and establish how best to interact, reviewing needs and opportunities. In connection with this, and in response to concerns raised about the possible detrimental effect on programmes if community workers are pulled from one programme to another with competing incentives, the Alliance was informed that a meeting for all the national programmes in the country is planned, involving the ministries of health and finance, as well as NGOs. In order to avoid conflicting programme interests and schedules, all districts require programmes to send their annual implementation plans and budgets to a central planning committee, which then allocates funds. Protocols govern visits to districts and the implementation of activities, which prevents overlap. The importance was stressed of priority-setting at the local level to establish which aspect of eye-care is the most important to the individual communities themselves. In Tanzania, although there is a national eye-care strategic plan, regional implementation plans reflect more specific priorities.

2.2 Ghana (Dr Maria Hagan)

TT surgery challenges

Ghana has a national eye-care secretariat and eye-care programme and has long recognized trachoma as a disease of public health importance. In 1995, the eye-care team drew attention to a disparity in care in the Northern Region, where only one case of TT surgery was being conducted for every 12 cases of cataract surgery

With support from WHO and several partners, including the Carter Centre, Christoffel Blindenmission (CBM), Sight Savers International (SSI) and the International Trachoma Initiative (ITI), planning meetings were conducted and a rapid assessment completed. In 2000, an epidemiological survey was made and programme activities in five districts started. In 2003 the picture was completed with 12 more districts surveyed and a five-year strategic plan for 2004 to 2009 drawn up. There is now support from a combination of partners for all components of the SAFE strategy in all districts, including donated azithromycin for all districts.

Human resources are a critical issue. Ghana currently has 2 ophthalmologists, 16 ophthalmic nurses and 650 primary health care (PHC) workers, with 4 more nurses and 200 more PHC workers in training. Community-based trichiasis surgery is performed free of charge, using the BTR procedure. Detailed records are kept of each operation, (e.g., name of surgeon, name, age, sex, address of patient, visual acuity, and which eye operated on). A manual is under development to support TT surgeons and a process of certification for surgeons is in process. Retraining is available. Studies are under way to assess the recurrence rate.

Overall, the ultimate intervention goal (UIG) for surgery currently is to operate on a total of 12 000 people (Table 1, Annex 3). The annual intervention objective for 2004 (originally of 2100 surgeries) had to be revised to 1200 surgeries because of resource constraints. Some of the new districts brought into the programme did not even have a single TT surgeon. Although 79% of the annual surgery target was reached, this was only 7.9% of the UIG. Coverage for the other components of the SAFE strategy was satisfactory, with excellent results for provision of water and latrines, thanks to the support of partners. The target for surgery in 2005 is 1500 cases, doubling to 3000 cases in both 2006 and 2007 in the expectation of having further trained practitioners.

The challenges include seasonal inaccessibility of certain communities, necessitating timely planning and execution of activities. Staffing is a major problem, but solutions are being tried, such as the training of health workers who already undertake surgical procedures to perform TT surgery as well. The existing surgeons will have most of their schedule committed to performing TT surgery.

Control activities in meso-endemic countries require more time and resources, particularly where compounds are far apart, requiring mobility. Epidemics of other diseases occasionally divert resources, for example to work on national immunization days for poliomyelitis eradication. Poverty is a problem in trachoma-endemic areas, and it is hoped that plans for blinding trachoma and cataract can be included in the GPRS (*Ghana poverty reduction strategy)* and that support will be given to upscale surgery for the two conditions. Ethnic conflict, particularly in the Northern Region, has reduced the programme's effectiveness, as personnel are unable to go in to conduct operations. Some people still have misconceptions about surgery and refuse to be treated, pointing to a need to intensify health education.

Among Ghana's successes are the facts that all districts have been surveyed and the SAFE strategy is being implemented; a trachoma five-year plan has been produced and is being implemented; the national eye-care strategy framework has been developed and launched by the Minister of Health; and four programme reviews have been held.

The principal failure has been an inability to meet surgery targets. Despite efforts to train supplementary workers, the standards have not been satisfactory, and the results are disappointing.

There are several opportunities. There is political commitment to the programme, and a structured approach. Blinding trachoma is a priority disease for elimination, mentioned in the Ministry's programme of work, and included in the five-year eye-care strategy document. Health staff have been trained for case detection and surgery, with a manual prepared, and a recording system established. These staff are monitored to ensure quality control.
All TT surgery is free and accessible, being community-based, with adequate equipment (surgical sets) and donated azithromycin.

The Director-General of health services has set the date of 2010 for elimination of blinding trachoma. While challenging, this is feasible, given certain assumptions for all elements of the SAFE strategy, such as that the trained TT surgeons are able to perform at