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

Geneva 29–30 March, 2004



GLOBAL ELIMINATION OF BLINDING TRACHOMA BY THE YEAR 2020

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1. INTRODUCTION

The eighth 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 29 to 30 March, 2004, attended by 84 participants (32 national representatives from disease-endemic countries; 22 representatives of governmental and nongovernmental organizations; 14 representatives from collaborating centres for the prevention of blindness and other research institutions and foundations; 5 donors/ observers from the private sector; and 8 technical staff from WHO, including staff from the regional offices of Africa, the Eastern Mediterranean and South-East Asia).

Robert Beaglehole, Director of the newly formed department of Chronic Diseases and Health Promotion, opened the meeting and welcomed all participants. He acknowledged the great value of the relationships forged between members of the Alliance; the interaction between epidemiologists, clinicians, researchers, foundations, nongovernmental organizations and industry was a model for WHO's work across the whole disease spectrum. Under the new Director-General the commitment was to improvement of people's health at country level, an emphasis that fitted well with the GET 2020 ethos. The public health challenges were clear: 84 million people whose sight was affected by trachoma, of whom 7.6 million had their sight seriously under threat from trichiasis. Interventions must be scaled up to reach all people in need, equity issues resolved, and resources further increased to meet demand. The greatest challenge, however, was for health systems, and it would be on this broad issue that the ultimate success of any programme would be judged. These must build on the primary health care foundations and grow through the trachoma elimination experience so that they were equipped and able to cope with the next global challenge to health. It was an ambitious agenda; he commended the work done so far and looked forward to learning of the results of the present meeting. Dr Serge Resnikoff, Coordinator of the WHO programme on blindness and deafness, added his welcome to participants, and particularly to the representatives of India and the United Arab Emirates; the two newest members of the Alliance. WHO was most grateful to the donors whose financial support had made it possible for the number of members to grow each year, and who thus brought the elimination goal nearer. Achievements in the last year included the updating of the global data on trachoma morbidity, the definition of the ultimate intervention goals (UIG) — for which term appropriate translations were invited — and the announcement of the donation of 135 million doses of azithromycin by Pfizer Inc.

Dr Jacob Kumarasan (International Trachoma Initiative) was elected Chairman of the meeting, and Dr Doulaye Sacko (Mali) as Vice-Chairman. Professor Sidi Ely Amidou (Mauritania) and Dr Anthony Solomon (London School of Hygiene and Tropical Medicine) were elected Rapporteurs.

The Agenda was adopted, modified to include a presentation by the United Arab Emirates (Annex 1). The list of participants is contained in Annex 2.

2. ACTIVITIES UNDERTAKEN SINCE THE SEVENTH MEETING

2.1 Report by the WHO Secretariat (Dr Silvio Mariotti)

The Second Global Scientific Meeting, on Ultimate intervention goals for trachoma control, was held in Geneva in August 2003.¹ The meeting was an important precursor to the GET 2020 Alliance meeting as it provided the tools (the UIGs) and the data that the following days' discussions by the GET 2020 working groups would refine. Participants at the August meeting had updated the available information on the regional and global burden of trachoma and defined UIGs as “the ultimate intervention to achieve the final target: the elimination of blinding trachoma by 2020”. The figures were dynamic, based on current estimates, which were themselves dependent on the quality of data available. Improved estimates would result in better-defined UIGs. The global scientific meeting had also clarified the situation with regard to countries with large populations and a high disease-burden, such as China, Ethiopia and India. Goals were established for each of the components of WHO's “SAFE” strategy (surgery, antibiotics, facial cleanliness and environmental improvements).

¹ *Report of the Second Global Scientific Meeting on Trachoma*, WHO/PBD/GET03.1

For the “S” component the UIG for trichomatous trichiasis (TT) was less than 1 case per 1000 population. That would correspond to more than one incident case of trichomatous corneal opacity per 10 000 total population per year. Programmes therefore should aim to reduce the current level of trichiasis cases to less than one TT case per 10 000 population, calculating the number of cases that required TT surgery, and working out feasible annual intervention objectives to reach the UIG. The initial assessment was made through active case-finding, estimating the total number of cases requiring TT surgery and then calculating the TT UIG. In many countries those goals would take a number of years to achieve. National coordinators should set annual intervention objectives based on: a needs assessment; the current availability of services; and the feasibility of increasing services (with training of key personnel to undertake the surgery being an essential aspect of this).

For the other components of the SAFE strategy, Dr Mariotti noted that assessment should start at the district level, focusing on children of 1–9 years of age, and on trichomatous inflammation –follicular (TF).

Referring to the “A” component he described an important change in WHO policy, whereby the threshold for mass treatment with antibiotics changed to a 10% prevalence. If TF prevalence was 10% or more, the whole district should be mass treated with antibiotics. If TF prevalence was less than 10% then treatment should be implemented only at community level. Repeated assessments would determine whether disease prevalence had been reduced and the intervention level could be shifted, for example, from community to family level. Based on the available data, the global recommendation was to conduct mass treatments for a minimum of three years. Those treatments must not be stopped until the TF level among children aged 1–9 had fallen below 5%. Where the rates were already very low in certain countries, flexibility would be needed. Coverage levels should be 80% of the eligible population (defined as all people living in communities where TF was at levels of 10% or more, although some age groups were not treated).

For the “F” and “E” components, the aim was that at least 80% of children in the community should have clean faces in order to break or reduce the infection cycles. After the first three years, the periodicity could change, with populations being resurveyed once every one to three years. That decision would depend on the level of endemicity of active trachoma among 1–9 year-old children, an assessment of the “clean face” status, and whether antibiotic treatment was indicated. The methodology for assessing the required periodicity after the initial three years was still under discussion, and would reflect a pragmatic balance between competing costs/demands and the level of involvement required. Rapid assessment tools were under review. Input from the working groups on those topics was expected. National coordinators were encouraged to find the current implementation status of Millennium Development Goals (MDGs) in each country and to do all they could to contribute to them.

Monitoring at national, district and community levels was especially important, particularly in those countries that were nearest to their elimination goals. The criteria and guidelines for the assessment of elimination still required finalization and debate.

Azithromycin had been included in the WHO Model List of Essential Medicines (13th edition, 2003) and in 2005 would be included in the WHO Model Formulary.²

Discussion: National coordinators noted the need for simultaneous implementation of all the components of the SAFE strategy, without which antibiotic treatment would fail to achieve the goals set. Although the UIGs were new to some at the meeting (and therefore would need time for assimilation and consideration) they were already a familiar and well-tried concept in other disease-control programmes, such as onchocerciasis. The concept of the UIG strategy had already been of direct use in Morocco, where it had helped to review and improve planning. UIGs were particularly commended as a tool for countries at the start of the planning process, where there would be short-term, medium-term and long-term needs and objectives to establish. Trachoma elimination faced the same problem as all other such elimination programmes: the lower the incidence of the disease, the harder — and more expensive — it was to find the remaining cases. Funding was also a considerable concern for developing countries in which prevalence was high, the need for antibiotics was great, but resources were limited. Donor support would be essential if those countries were to cope with the implications of the new strategy, both to support the number of doses required and to administer the periodic surveys.

² Available on the Internet at: www.who.int/medicines

2.2 Reports from trachoma-endemic countries: Members of the Alliance

Afghanistan (Dr Ahmad Shah Salam)

The prevalence of blindness in Afghanistan is 1.5–2%, with corneal opacity, the second highest cause of blindness, accounting for more than 10% of the country's total blindness. The prevalence of low vision is 4.8% and severe visual impairment is 1.95%. Data from a hospital report showed 6% of its blind population to be children (26 out of 445 cases). There were more than 850 cases of trichiasis in 2002 in total.

There are active trachoma cases in every province, with disease-endemic areas in provinces in the north and west of the country. A study among 624 orphanage children in Kabul showed a prevalence of active trachoma of 0.6%. In a report based on Mazar ophthalmic centres (northern province), the prevalence of active trachoma was 1.35% in the whole age group. Similarly a report from the Herat ophthalmic centres in the western province gave a prevalence rate for active trachoma of 1.54%.

Environmental conditions are harsh; there are poor sanitation facilities (access to adequate sanitation for only 12% of the population and only 13% with access to safe drinking-water). Infant mortality among children under five years of age is high (257 per 1000 live births). Afghanistan has limited numbers of technical staff in the country, almost exclusively in urban areas. There are 93 eye doctors (not all of whom perform surgery), 6 optometrists, 23 refractionists/technicians, and 71 ophthalmic nurses. More than 99% are national eye-care health workers. There are four training centres for eye-care workers.

The five-year national plan for comprehensive eye-care started in 2002 with a focus on developing provincial and district primary and secondary eye-care complexes. Eye-care services are still limited; there are some eye-care centres in three provinces but none at district level. Primary eye-care is integrated in primary health care (PHC). Although there is no national programme specifically for trachoma control, the disease is dealt with in eye-care centres at provincial level with some outreach activities (including data collection, follow-up and evaluation) and the Government is supportive of the overall eye-care programme. A national committee has been formed, representing a range of partners, including ministries, international nongovernmental organizations (NGOs) and organizations such as IAM (International Assistance Mission) and SERVE (Serving Emergence Relief and Vocation Enterprise). The launch of a Vision 2020 campaign, with strong political backing from the Ministry of Health, has been planned for April 2004, followed by a donor conference. In future, within the five-year national eye-care plan, trachoma rapid assessments will be carried out in 22 provinces; areas of greatest need will be identified and prioritized; a national trachoma plan based on the SAFE strategy will be formulated; and that plan will be implemented, monitored and evaluated.

Discussion: The launch of the Vision 2020 initiative should improve the funding and supply of antibiotics; currently not even tetracycline was available in some provinces. Donor support to provide azithromycin was needed. Despite the lack of population data there was no doubt of Afghanistan's needs; trachoma was a major blinding disease in certain areas, and very little PHC was available. Through Vision 2020, the development of trachoma control and eye-care services could importantly strengthen the health care system. The lack of water was a critical issue too; in Kabul, each household had only one hour's supply of drinkable water each week. WHO's Eastern Mediterranean Regional Office was committed to providing help and coordination of other interested parties ready to support Afghanistan's progress.

Australia (Professor Hugh Taylor)

World Health Assembly resolution WHA56.26 (Elimination of avoidable blindness) has had important consequences for many countries, including Australia, one its sponsors. For example, a Trachoma Steering Committee has been created as part of the national communicable disease group. Trachoma is no longer present in the urban white Australian population but is prevalent in pockets among the aboriginal population, especially in the north and west of the country, where prevalence rates of follicular trachoma are commonly 55–60%, with high rates among children. Most the data collected result from screening of schoolchildren. There are significant numbers of communities with intense levels of trachoma; in a community study in central Australia levels of 40% were found in schoolchildren aged below 13 years of age. In Arnham Land, Northern Territory, in a study of 15 schools, levels of 20–50% were found in three schools and above 50% in six schools. In South Australia, two community studies

(2000 and 2001) found TF prevalence rates of 58% in 1–9 year-olds, with a TI rate of 11%. Azithromycin has been distributed in some areas, although rather unsystematically, for the last 8–10 years and there is a consequent gradual reduction in the amount of trachoma. There is no marked gender difference; rates of trichiasis among men and blindness due to trachoma are a little higher than among women. Differences in prevalence between genders reflect the intensity of transmission and high prevalence, and the absence, in Australian children, of the marked gender-role differences in 6–7 year-olds observed in other Asian or African cultures.

Discussion: The context for prioritizing trachoma as a public health issue was explored, with discussion of the various other agendas and problems experienced by the aboriginal communities, with which this health issue had to be balanced. Trachoma was viewed as a priority in the 1970s and 1980s but, without continued advocacy and vocal leadership, was supplanted by other health issues, such as the hundredfold increase in diabetes among aboriginal populations in the last 20 years. It was disturbing that conditions conducive to the spread of trachoma were still so prevalent. The Government was committed to having a plan by 2005, implemented by 2007, and reporting back to the Health Assembly by 2010. The situation in Australia provided evidence that specific interventions and approaches were needed but had to be part of health sector development if they were to compete successfully for attention with other health issues, HIV, for example. The Alliance itself was a powerful tool for gaining attention and should be more visible in a political sense, for example presenting information about trachoma and the UIGs at the Health Assembly. Resolution WHA56.26 requested the Director-General to report to the Fifty-ninth World Health Assembly on the progress of the Global Initiative to Eliminate Avoidable Blindness; that level of accountability provided a good opportunity to lobby government interest and raise the profile of trachoma activities, along with other opportunities such as World Sight Day.

The principal issue in Australia was living conditions, such as inadequate housing. Only 20-25% of the houses surveyed had hot and cold running water at any given time, with electricity run by diesel generators. Rubbish was only collected occasionally. Antibiotics were distributed rather haphazardly. Data collection in recent years has been sporadic, generated at local, district or territory level, but not consistently available at Federal or Commonwealth levels.

Brazil (Dr Norma Medina)

Preliminary results were available from 11 states (out of a total of 27 states) in a national trachoma school survey of underserved schoolchildren in public schools from 1–4 grades (covering ages 7–10 years). The study is very important for trachoma control in Brazil because it provides data on areas about which there was previously no information and clarifies misconceptions about the location and presence of active trachoma. The 2002–2003 survey targeted municipalities where the human development index is lower than 0.742 (the median for Brazil), sampling 7200 children in each state. Ninety-eight percent of the trachoma cases found among schoolchildren are TF, 0.1% are TI, and 0.1% TS (trachomatous scarring). Cases were treated with tetracycline (1%) with follow-up after nine months and eye examinations were made of all household contacts. The total, overall prevalence rate (from the 11 states' data) is 5.2%. The highest prevalences in the country are in Acre (north Brazil) followed by Ceará (north-east). Certain municipalities in Acre and Roraima (where there is a large Indian population, treated with azithromycin) have trachoma prevalence rates of 10–20%. Of the states in the north-east, only Ceará has a high rate, of 7%. In Bahia, formerly a problem area, prevalence rates have dropped considerably. Until the present survey no data had been available for the presence of trachoma in Acre. Similarly, the most southerly state of Brazil, RG Sul, a rich state, was found to have a prevalence rate close to that of São Paulo, with pockets of high prevalence although trachoma had not been reported in RG Sul in the last two decades. Laboratory tests confirmed this finding. In addition to examining schoolchildren, a survey had been made of household contacts. In 2004, 10 more states will be surveyed which will further clarify the situation.

Discussion: The problem of cross-border trachoma control was raised, and the difficulty in monitoring and treating diseases in mobile populations. Given the identification of trachoma, for example, in areas bordering Bolivia, Guatemala and Venezuela, and the existence of mobile Indian populations, it would be timely to reconsider the previous findings that trachoma was not present in those countries. The prevalence of active trachoma among children aged 0–6 years was thought to be a little higher than among the schoolchildren surveyed, on the basis of the household inspections made for antibiotic treatment. A further survey would be needed to establish TT prevalence, although it was known that the ophthalmological services frequently operated on TT cases. The “A”, “F”

and “E” aspects of the SAFE strategy were being implemented; the “S” element had been more difficult to address. It was observed that, on the basis of the data available, it was difficult to assess the scale of the public health problem; further investigation at household level would be needed to establish the level of blinding trachoma in the areas where trachoma was now known to be prevalent.

Burkina Faso (Dr Bernadette Yoda)

The trachoma prevention activities among the 13 health regions and 55 health districts in Burkina Faso are integrated within the overall national plan for blindness prevention. Trachoma control workshops were held in 2003 to conduct microplanning with partners for the five most affected regions. Each district and region submitted annual action plans, which were then integrated, and held in readiness until sufficient technical and financial resources were in place to implement them. Lack of resources meant that only one of the five regions (La Boucle du Mouhoun) has been able to carry out the plans in four districts in training of health workers, and in organization of trachoma control days using the SAFE strategy. In that one region, 120 nurses have been trained in trachoma screening, 8 TT operators, 360 instructors for children, and 120 community workers for advocacy and sensitization activities within the communities. During trachoma control days, 2500 examinations have been carried out, 250 cases of active follicular trachoma have been found, and 173 trichiasis operations have been carried out.

In the rest of the country, activities such as trichiasis surgery continue, both in fixed centres, and through the work of mobile teams. Eight hundred trichiasis operations have been carried out during the “days for trachoma control”, and tetracycline (1%) has been distributed. Efforts to improve facial cleanliness have been supported by the education system, and NGOs and other partners, through programmes in 17 schools, and a new school health curriculum has been tested in eight schools in the Est region.

A meeting of partners, including WHO, UNICEF, CBM (Christoffel Blindenmission), HKI (Helen Keller International), the Lions Club, Save the Children, and others, was held in January 2004, at which a firm commitment with health authorities has been made to establish a national blindness control committee. Work on integrating blindness control efforts among regional coordinators has started but more technical and financial support is needed. Burkina Faso wishes to establish a partnership with ITI (International Trachoma Initiative) to benefit from the azithromycin donation project. An action plan for trachoma control over the next five years is in development, as is a project for prevention and case management of trichiasis and cataract in three health regions. This was presented to partners for their consideration; and a plan for Vision 2020, with a workshop to validate it.

Cambodia (Dr Do Seiha)

The current magnitude of trachoma prevalence in Cambodia is unknown. There are estimates based on hospital data from Svay Rieng (in the east of Cambodia) and Battambang (in the west); community surveys in northern and central Cambodia; a national micronutrient survey in 12 provinces, and rapid assessments in three provinces (there are 22 provinces in total). The estimates put TF/TI prevalence at 22.6% for children under 10 years of age, and prevalence of TT for people over 14 years of age at 3.56%.

There is no national trachoma control programme in Cambodia; all trachoma activities are carried out at the

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