



WORLD HEALTH ORGANIZATION
Prevention of Blindness & Deafness

WHO/PBD/GET/04.1

Report of the Seventh Meeting

of the WHO Alliance for the

Global Elimination of

Blinding Trachoma

Geneva, 6-8 January 2003



GET 2020

GLOBAL ELIMINATION OF BLINDING TRACHOMA BY THE YEAR 2020

© World Health Organization. 2004

All rights reserved. Publications of the World Health Organization can be obtained from
Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland
(tel.: +41 22 791 2476; fax: +41 22 791 4857).

The designations employed and the presentation of the material in this publication
do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal
status of any country, territory, city or area or of its authorities,
or concerning the delimitation of its frontiers or boundaries.

Dotted lines on maps represent approximate borderlines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products
does not imply that they are endorsed or recommended by the World Health Organization
in preference to others of a similar nature that are not mentioned.

Errors and omissions excepted, the names of proprietary products
are distinguished by initial capital letters.

The World Health Organization does not warrant that the information contained in this publication
is complete and correct and shall not be liable for any damages incurred as a result of its use.

295010
2

CONTENTS

	Page
1. INTRODUCTION	1
2. REPORTS OF ACTIVITIES UNDERTAKEN SINCE THE LAST MEETING.....	1
Endemic countries – members of the Alliance	1
Afghanistan.....	1
Brazil	2
Burkina Faso.....	2
Cambodia.....	3
Chad.....	3
People's Republic of China.....	4
Egypt.....	5
The Gambia	6
Ghana.....	7
Guinea.....	8
Kenya.....	9
Lao People's Democratic Republic.....	9
Mali.....	10
Mauritania.....	11
Mexico	11
Morocco.....	12
Mozambique	13
Myanmar.....	13
Nepal.....	14
Niger	14
Nigeria	15
Oman	15
Pakistan.....	15
Senegal.....	16
Sudan	17
Republic of Tanzania.....	19
Uganda.....	20
Viet Nam.....	20
3. NEW ORGANIZATIONS	21
ACASAC.....	21
Kilimanjaro Centre for Community Ophthalmology	22
4. WHO GLOBAL OVERVIEW	23

	Page
5. IMPLEMENTATION OF THE SAFE STRATEGY AT THE COUNTRY LEVEL: SWOT ANALYSIS BY COMPONENT (working groups).....	25
5.1 Working Group 1 (Burkina Faso, Guinea, Mali, Mauritania, Morocco, Niger, Senegal).....	25
5.2 Working Group 2 (Afghanistan, Egypt, Oman, Pakistan, Sudan).....	26
5.3 Working Group 3 (The Gambia, Ghana, Kenya, Malawi, Nigeria, United Republic of Tanzania, Uganda)	28
5.4 Working Group 4 (Brazil, People's Republic of China, Mexico, Lao People's Democratic Republic, Nepal, Viet Nam)	31
6. UPDATE ON TCDC PROGRESS AND SYNERGY WITH VISION 2020	33
7. ANY OTHER MATTERS	33
Report of the Scientific Workshop.....	33
CONCLUSIONS AND RECOMMENDATIONS.....	35
ANNEX 1. Agenda.....	37
ANNEX 2. List of participants	38

1. INTRODUCTION

The Seventh Meeting of the WHO Alliance for the Global Elimination of Blinding Trachoma was held at the headquarters of the World Health Organization, from 6 to 8 January 2003.

The meeting was opened by Dr Serge Resnikoff, Coordinator of the WHO programme for the Prevention of Blindness and Deafness, who expressed recognition of the efforts already carried out by participants. Trachoma, he indicated, was a disease that affected the least favoured sectors of society – the problem was immense, and limits could not yet be defined. Resources were scarce and needed to be used effectively. Dr Resnikoff welcomed Afghanistan, the People's Republic of China, Mexico and Uganda for the first time. The Alliance would define the current situation, try to measure progress and consider possible synergies.

There were ongoing activities in almost all countries, and the Alliance was beginning to have a very positive effect on the attempt to eliminate blinding trachoma. There was collective action between nongovernmental organizations (NGOs) and governments, which was what had been sought. Most attending countries, apart from Nepal and Afghanistan, reported programmes in action, although not covering the entire country in all cases. There was some difficulty reported in obtaining finalized figures for 2002, due to the early meeting date. Dr Resnikoff explained that the meeting had been moved up because of the election of the new Director-General of the World Health Organization and that next year's meeting would be from 22 to 24 March 2003.

Dr Youssef Chami Khazraji was elected Chairperson of the meeting and Dr Peter Kilima Vice-Chairperson. Ms Hannah Kuper and Dr Amza Abdou were elected Rapporteurs.

The provisional agenda was adopted with no modification (Annex 1). The list of participants is contained in Annex 2.

2. REPORTS OF ACTIVITIES UNDERTAKEN SINCE THE LAST MEETING

Endemic countries – members of the Alliance

Afghanistan

Afghanistan was, at present, better than during the war, but illiteracy and a bad economy and health education system were problems currently facing the country, even during peacetime. There was a high incidence of blinding trachoma, seen by Afghan ophthalmologists and known to be there, but war and the displacement of the population precluded good population statistics. Some doctors and NGOs, however, had local statistics. There was more trachoma in northern, central and western Afghanistan, and in some provinces in the east. Since completely preventable, the disease could be controlled with a good plan. Technical support was needed from WHO, and more assistance in medications, surgical instruments and financing. Trachoma was not a disease of the rich, and treatment should be free. Negotiations were being attempted with NGOs with a view to providing water to help with clean faces. There was a need for sulfonamides and tetracycline. Trachoma was currently being treated privately in Afghanistan, and help was requested in addressing the country's problem, since the disease was a disease of the poor.

Discussion

WHO had held a workshop in Afghanistan, making recommendations to the Ministry of Health on the establishment of a comprehensive national eye care programme. The draft document was ready and included all diseases. It was true that the country needed assistance, or would be left behind, and it was already a victim of terrible neglect. The value of partnership was underscored, and there was an opportunity to work together and bring in the resources that partners were keen to provide. The VISION 2020 Task Force was aware of the needs in Afghanistan, and there was a definite recommendation that the regional coordination groups be very active. The WHO Regional Office for the Eastern Mediterranean was keen and ready to support Afghanistan through human resources, development of capacity-building, materials and the seeking of NGO support. World Vision noted the need for water, and their water specialist would be sent to Afghanistan to survey and to report.

The Kingdom of Morocco offered a donation of tetracycline within the framework of cooperation of members of the Alliance and members of the Eastern Mediterranean Region. The needs should be outlined, particularly for children who might be affected by active trachoma. It was believed that free distribution to ophthalmologists in the provinces and in rural areas would be most effective in getting rid of some percentage of trachoma.

Brazil

The results of the trial of azithromycin done in Sao Paulo showed that in Brazil, at the year interval, a single 20 mg/kg dose of azithromycin was giving equivalent results to tetracycline twice a day for six weeks. However, at earlier stages (three, six and nine months), tetracycline performed better. This was perhaps due to the fact that the study was being conducted in the city of São Paulo, where the prevalence of trachoma is low (2.2%). Sao Paulo did not report any trachoma until the 1990s. Diverse reactions were reported in 39% of the tetracycline patients and in 24% of the azithromycin patients.

In 2002, a national epidemiological survey was conducted in four States.

Brazil had restructured its plan in the last five years, from a centralized vertical programme to Federal and State levels, concentrating only on the endemic areas. In the Indian Tocantin area of the Amazon in 2000, over 50 000 cases of trachoma were diagnosed, along with TT and CO. In 2000, the Government allowed any city where trachoma had been diagnosed to request funds for environmental sanitation, and 500 people were trained to work with the problem.

At one point, trachoma appeared to be below the level of concern, but later reappeared, making the implementation of the SAFE strategy important for prevention. In the 1970s, a survey of schoolchildren identified a prevalence of trachoma of more than 20%. While 20 States had been working with this problem, by 1997 only six were working. It was also reported that, while certain areas had been considered endemic-free, pockets had now been discovered.

Burkina Faso

In a country of 10 300 000 inhabitants, where 45% of the people were below the poverty line and the economy largely agricultural, trachoma was estimated in 1997 (by a top ophthalmological institute) at 26.8% trachoma and 5.1% trichiasis. It was still considered a public health problem in Burkina Faso and was the second largest cause of blindness.

In December 2001, there was a "trachoma day", with 1000 cases, 300 operated, 48 agents trained in screening and 18 trained for surgery. During the first quarter of 2002, 1600 cases were detected and 400 cases had surgery.

The lack of a high level of activity was due to several factors: lack of funding by partners, no separate trachoma control programme, difficulty in detecting cases, insufficiently trained health personnel, and the delay until October 2002 in appointing a national coordinator following the departure of the previous coordinator in December 2001.

The objective was to reduce trachoma by 50% by 2005. The priority was prevention, and intrasectoral as well as intersectoral collaboration was being sought. Activities had been identified in which participation (technical equipment, etc.) would be appreciated from each partner.

The depletion of stocks of tetracycline was a concern, as well as the cost. Tetracycline currently cost US\$ 0.30 per tube, and two tubes were needed. The compliance rate was unknown, since prescriptions were distributed in mass campaigns; there was a problem in follow-up. Most family members had the disease. Community health centres distributed tetracycline.

The political commitment existed, but more financial resources needed to be committed to the problem. That had prevented the programme of activities from being carried out fully since 1997, taking place only in certain villages and including school education in ocular hygiene, etc., for both teachers and children.

Cambodia

In April-May 2000, a Trachoma Rapid Assessment (TRA) was conducted in three provinces of Cambodia – Takeo, Prey Veng and Svay Rieng.

The 2002 activities through October were: 28 days of eye camps; 553 adults screened; 44 surgeries performed; and 2031 schoolchildren screened. In addition, educational materials for trachoma were developed and printed, 60 village health workers (VHWs) received trachoma training, seven children with active trachoma were treated with antibiotic eye ointment and 167 schoolchildren were screened.

Chad

Chad was a very large country of 1 200 000 km², with a population of 7 500 000 and three climatic zones. It was an extremely poor country, of mainly agricultural and pastoral activities. There had been no national coordinator for the last year.

There were 14 health areas, 22 health districts and a three-tier health system. There was the general national referral, the intermediate level that provided a complementary package and the peripheral level represented by health zones providing a minimum package. In 1995, the prevalence of blindness was estimated at 2.21%; this was still so, and the causes of the more than 150 000 cases of blindness were cataract, trachoma, glaucoma, corneal opacity and onchocerciasis.

Two pilot surveys were carried out in five health areas in the year under report. The results were that the rate of prevalence for TI and TF was 43% in the first survey (113 000 people) and 53.1% in the second survey, with 239 000 people requiring treatment. The prevalence of tissue and scarring blindness was 1.7% in the first survey (3493 people) and 1.1% in the second survey (3889 people). The totals in the five health areas were more than 352 000 people who should be treated and 7400 people who should be operated.

In 2001, only 368 operations took place. In the second survey area, there were no operators for trichiasis, so training was provided for trachoma surgery and equipment for 10 health regions where the first survey was carried out. Twenty thousand tubes of tetracycline were purchased and had been distributed through WHO, OPC and the Swiss Red Cross.

In 2002, there had been few activities, due to the lack of a coordinator for more than a year.

The problems were (1) the lack of qualified personnel, (2) the lack of transport for mobile teams, and (3) the lack of supplies, drugs and consumables.

The solutions would be (1) a training programme, (2) support from WHO and OPC for camps, (3) the acquisition of mobile facilities, (4) the organization of a further survey, (5) an intersectoral committee – Ministry of Public Health, Ministry of Water and Environment, and (6) Ministry of Agriculture, Ministry of Education and Communication, and partner NGOs (OPC and the Swiss Red Cross).

The Swiss Red Cross was instrumental in allowing a workshop for a three-year action programme for 2003-2005, principally for trachoma control, emphasizing the SAFE strategy, and for cataract.

People's Republic of China

China had reduced its trachoma problem from 50% of the total population in the 1960s to 3% in 2001, but it was still approximately 10% in trachoma-prevalent areas. The great improvement had been credited to the fighting action of ophthalmologists and the Government. Four booklets released by WHO had been translated into Chinese and provided to the relative hospitals and institutions.

Trachoma therapy training courses had been undertaken by the WHO Collaborating Centre for the Prevention of Blindness in China and the national and local prevention of blindness directory offices. Public education was carried out via community public posters, broadcasting, television, etc.

In the 1960s, trachoma was the first cause of blindness; now it was the third. Trachoma was disproportionately found in rural areas, with very little in the urban areas. Approximately six million persons needed trichiasis surgery. Topical antibiotics currently used were rifampin, erythromycin, tetracycline and sulfadiazine, the latter being less used and only in city hospitals. Azithromycin was less used because of price and patent. Two thousand county hospitals performed

预览已结束，完整报告链接和二维码如下：

https://www.yunbaogao.cn/report/index/report?reportId=5_30121

