

**ELIMINATION OF
BLINDING TRACHOMA:
ONLY 10 YEARS TO GO**

**Report of the Fourteenth Meeting of the
WHO Alliance for the Global Elimination of Blinding Trachoma**

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1. Introduction

The Fourteenth 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 (WHO), Geneva, Switzerland, from 19 to 21 April 2010. The objectives were to undertake the Alliance's annual review of progress towards elimination at the global level, to exchange information on the SAFE strategy and to examine partnership opportunities (Annex 1).

The meeting was attended by 55 participants, including 14 national coordinators for trachoma control programmes (Annex 2). Dr Georges Yaya (Central African Republic) was elected Chairman and Mr Simon Bush (Sight Savers International) Vice-Chairman. The meeting should have been the largest in the history of the Alliance. Unfortunately, owing to disruption to air travel caused by a cloud of volcanic ash, participants had difficulty in travelling to Geneva, and many were unable to attend in person. This resulted in some adjustments to the agenda and the arrangement of a teleconference session.

Dr Ala Alwan, Assistant Director-General of the World Health Organization (WHO), Noncommunicable diseases and Mental Health, and Dr Hiroki Nakatani, Assistant Director-General of WHO, HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases, welcomed participants. They drew attention to the significant progress made in reducing the global trachoma burden since the establishment of the Alliance in 1997 thanks to the implementation of the SAFE strategy – eyelid surgery (S), antibiotic treatment (A), facial cleanliness (F) and environmental improvement (E) – but noted that special efforts will be needed to expand and accelerate trachoma control programmes if GET 2020, now only 10 years

away, is to be attained. Attention to obstacles to progress will be crucial. It will also be important to take advantage of the opportunities provided by recent changes in global attitudes and responses to the financing of public health initiatives, the development of integrated approaches to the control of neglected tropical diseases (NTDs), including trachoma, and the rising interest in progress towards the Millennium Development Goals.

2. Review of trachoma data forms

Dr Silvio Paolo Mariotti, Medical Officer, GET 2020 Secretary, World Health Organization, Geneva, Switzerland

Progress towards the GET 2020 target is monitored through the trachoma data forms submitted by countries each year. Trachoma data forms were sent to 44 of the 57 trachoma-endemic countries. The form had been modified to reflect recent suggestions and comments and to include a request for data collected at the district level. Completed forms were received from 36 countries (82%) compared with 40 of 45 sent (89%) in 2009 and 38 of 45 (84%) in 2008. However, a substantial proportion of endemic countries are still not reporting. Completion of the trachoma data form is a complex process and partners are urged to support national trachoma task forces in providing reliable data and in submitting the forms on time. The aim is to obtain a detailed picture of the epidemiological situation, implementation of the SAFE strategy and national settings, including the NTD framework and political and partner support.

The information will be included in the new WHO integrated NTD database, which should prove a useful tool in monitoring global progress and attracting support from new partners.

District-level data were included in 83% of completed forms compared with 68% in 2009. The findings indicate an encouraging increase in consistent use of annual intervention objectives (AIOs) and ultimate intervention goals (UIGs), and in antibiotic coverage at the district level. There is also an increase in the use of evidence-based data rather than estimates to set and monitor progress towards objectives and targets. Delivery of the entire SAFE package is improving. Reporting on the F and E components is increasing, although implementation of these components requires better coordination across the different sectors involved. Some countries have strong and effective partnerships and national trachoma task forces. However, the findings also reveal that not all countries are setting AIOs and UIGs, that countries not receiving antibiotic donation appear to have greater difficulties in reporting, that lack of sustained political can lead to disruption of trachoma control activities, and that ownership by national programmes remains variable.

Country highlights include the attainment of the UIG by Ghana, the start of surveillance in Ghana and Mali, and government investment in the elimination of blinding trachoma in China. More countries have set clear target dates for elimination and two countries have advanced the dates. New partners are becoming involved and, thanks to Alliance advocacy efforts, major NTD donors are recognizing and adopting the SAFE strategy.

Information on the number of endemic districts was provided on 92% of forms and gives a good indication of the work needed to achieve GET 2020. Information on coverage with trichiasis (TT) surgery (S) in relation to the 2009 AIO was provided by

30 countries (83% of forms); only two achieved the AIO and 12 failed to reach 50% of the target. The backlog of cases in reporting countries is around 3.8 million.

Antibiotic coverage (A) was reported by 27 countries (75%); nine achieved the AIO and a further six reached around 80%. Although this represents a significant improvement, the shortfall is still 135 million treatments. Reporting on facial cleanliness (F) was not consistent. Of the 28 countries that provided data, 11 achieved the AIO and further two reached >80%. Information on environmental improvement (E) was obtained by asking whether activities were under way to attain Millennium Development Goal 7 (Ensure environmental sustainability). Of the 34 countries that responded, 31 have a Goal 7 plan.

The completed forms indicate that there is an urgent need to expand and accelerate the implementation of the SAFE strategy in all endemic countries. While antibiotic coverage is increasing steadily, the slow pace in tackling the backlog of TT surgeries and in monitoring and follow-up of surgery remain serious challenges.

Work on procedures for the certification of elimination of blinding trachoma as a public health problem is continuing. A draft protocol will be finalized at the Third Global Scientific Meeting on Trachoma to be held in July 2010 and the revised protocol will be presented to the Alliance at its Fifteenth Meeting.

3. Report of the International Coalition for Trachoma Control

Mr Chad MacArthur, Director of NTD Control, Training and Community Education, Helen Keller International, New York, NY, USA

The 2009 meeting of the International Coalition for Trachoma Control (ICTC) was held from 22 to 23 July in Geneva, following the Thirteenth Meeting of the Alliance, with 13 partners in attendance.

The meeting discussed the role of ICTC in light of developments in the control of NTDs, including trachoma, and the funding of control activities, and decided that ICTC should become a member of the NTD Nongovernmental Development Organization Network. The Network, established in September 2009, includes among its members the Nongovernmental Development Organization Coordination Group for Onchocerciasis Control, the Lymphatic Filariasis Nongovernmental Development Organization Network and nongovernmental organizations providing support for the control of schistosomiasis and soil-transmitted helminths. It hopes to increase the expansion and effectiveness of advocacy for NTD control; to facilitate the formation of partnerships at the international, regional and national levels; and to provide a mechanism for coordination of nongovernmental organization activities at national and international levels. The Network will share new technical information, develop and seek to uphold best practices, and contribute to the formulation of WHO guidelines. It will also support the development and maintenance of national task forces in NTD-endemic countries. Links with other relevant bodies, such as the African Programme for Onchocerciasis Control, are being pursued. The next meeting of the Network will be held in September 2010 in Atlanta, GA, USA, hosted by the Task Force for Global Health.

It is important to take advantage of the raised profile of NTDs and to ensure that trachoma control activities and the SAFE strategy are fully represented within NTD activities. Moreover, the new Network should benefit from the Alliance's years

of experience. However, it is also essential to maintain a trachoma-specific interest. ICTC will therefore continue to hold an annual meeting following the annual meeting of the Alliance, as well as attending meetings of the new Network.

ICTC reviewed its terms of reference and renewed its commitment to the identification and motivation of other partner organizations, especially those active in F and E areas. To complement the information provided through the trachoma data forms, the Coalition (with the help of a consultant from the International Trachoma Initiative, ITI) has started mapping nongovernmental organization assistance to national trachoma task forces, district-by-district, in each country, using specific indicators, which will be consistent with existing indicators for each of the SAFE components. This exercise will also update the mapping of nongovernmental organization presence in countries, which is currently uneven. The initiative will be discussed in greater detail during ICTC's next meeting.

4. Report of the Trachoma Informal Scientific Workshop 2010

Dr R.B. Khandekar, Ophthalmologist, Epidemiologist, Eye & Ear Health Care, Eye Health Care Programme, DAHA, Ministry of Health, Muscat, Oman

A total of 26 experts participated, three of them by teleconference, in the 2010 meeting of the Trachoma Informal Scientific Workshop (TISW), which was held on 16 April 2010 at WHO headquarters. The meeting reviewed selected research studies

and agreed to submit the following conclusions and recommendations for national programme managers of control programmes for trachoma and other NTDs.

Good quality sutures are essential for successful outcomes in TT surgery. Surgeons should therefore monitor their performance and allow time in the immediate postoperative period for re-suturing to remedy over- or under-correction. TT surgery should be consistently supervised during training and monitored in the field.

Mass antibiotic treatment campaigns offer an opportunity to provide health education to reinforce messages and induce behaviour change. Planning for such combined delivery should be included in national action plans. In a small study in Cameroon, administration of topical azithromycin drops in children aged 1–10 years twice a day for three days produced a good reduction in the prevalence of active trachoma after one year. However, the cost is high and this treatment is not yet recommended for adoption in national programmes. In villages where trachoma prevalence is >15%, a single round of treatment is not enough, even if coverage is very high. Programmes should implement the recommendation of at least three rounds, with coverage of >80%. An assessment should be made after three rounds to determine whether further rounds are needed. Antibiotic treatment rounds should be continued pending completion of the assessment to avoid any resurgence of the disease. Treatment coverage should not be assessed by dividing the number of doses administered by the estimated population total; better, more objective assessment methods should be considered. Programmes should include plans to deal with marginalized families or individuals that fail to participate in mass treatment and should involve sufficient personnel to achieve “true” high coverage.

Cost analysis of 197 district-level active trachoma prevalence surveys in Africa that used a sampling structure of 15–24 clusters, suggests that the cost of such

surveys is in the range US\$ 3000–6000 per district, depending on geographical conditions, population density and logistics. Major costs include per diem and other personnel costs, and transportation; and data entry accounts for around 10%. Budgets should cover all these elements. If the estimated prevalence of active trachoma prevalence in a district is >15%, a randomized cluster sample of <30 clusters (villages) may be adequate to provide a reasonable estimate. However, it is important to ensure that the sample covers all geographical areas within the district.

Research is continuing on a laboratory-based method to assess chlamydial infection. However, this is not yet ready for field application. Further research is needed on comparing the laboratory-based method with clinical grading of active trachoma.

Discussion

Under current procedures, any organization may submit operational and scientific trachoma research studies for consideration by the TISW, and proposed presentations are scrutinized for relevance before being submitted to the Workshop. Participants suggested that it might be useful to invite nongovernmental organization and national representatives: to identify key operational questions that required further research and to attend TISW meetings; to broaden the range of papers reviewed to include economic and anthropological aspects; and to map ongoing trachoma research and research networks. The meeting agreed that more transparent procedures should be established in relation to the membership of the TISW and the procedure for selecting research studies for review.

5. Azithromycin donation: report from the International Trachoma Initiative

Dr Danny Haddad, Director, International Trachoma Initiative, Task Force for Child Survival and Development, Decatur, GA, USA

ITI merged with the Task Force for Global Health in 2009. It has renewed its vision of a world free of blinding trachoma and its commitment to the elimination of blinding trachoma by 2020 by managing the donation of azithromycin (Zithromax) provided by Pfizer Inc. and by collaborating with partners to ensure the implementation of the full SAFE strategy. Strategic planning discussions recommended that ITI should focus on three key roles within a more comprehensive plan: managing the supply chain for the azithromycin donation; acting as a primary advocate at the global, regional and country levels for the elimination of blinding trachoma; and being involved as a key partner in trachoma knowledge management.

A huge scaling-up of trachoma control activities implemented through the full SAFE strategy is needed over the remaining 10 years if GET 2020 is to be achieved. Since three to five rounds of antibiotic treatment are required, treatment will need to have started in every endemic district by 2015. In order to satisfy the increased demand for azithromycin this will entail, ITI and Pfizer will require accurate forecasts of needs for all countries by 2012. It is therefore essential to start mapping and implementing programmes as soon as possible.

ITI has developed a new application process for azithromycin donation comprising four steps: completion of an annual application form; a forecasting meeting; review of the application by its Trachoma Expert Committee; and the

negotiation of an annual agreement. A prefilled form, containing data from the previous year, will be sent to countries in January for careful verification, amendment as necessary and return to ITI by the end of February. The completed forms should include all possible information, including on districts where treatment has not yet started and on areas that do not require antibiotic, that still need mapping or where the situation is unknown. All partners are asked to help national trachoma task forces to complete the forms. Forecasting should cover 100% of the eligible population. In general, 80% will receive azithromycin tablets (5 years and older), 18% azithromycin paediatric oral suspension and 2% tetracycline eye ointment (6 months–5 years), but if adequate evidence is available, the proportions can be adjusted. ITI will review the forms and follow-up any questions that arise. ITI will convene an annual forecasting meeting with national representatives and partners, to be held in conjunction with the annual meeting of the Alliance, to clarify needs and report on progress in antibiotic distribution. Preliminary forecasts will then be reviewed by the Trachoma Expert Committee, which meets in June and December, for final approval of the azithromycin allocation. The Committee comprises seven members with experience in different aspects of trachoma control. The review will ensure that countries have the capacity to distribute the drug and that distribution will be part of the full SAFE strategy. Annual agreements will then be sent to countries, for return by October–November. ITI must receive a country's signed agreement before shipping can commence. Allocations are made by district rather than as a total country allocation, and any in-country reallocation must have prior approval ITI.

Countries that have not previously received donated azithromycin are required to provide: a completed application form giving information on all districts, including those that still need to be surveyed and those that are non-endemic; a full prevalence

report; and a national plan. The plan should include a specific trachoma control plan for the first three years, showing sustained support for at least three rounds of mass drug administration distributed as part of the SAFE strategy; it can subsequently be integrated in a Vision 2020 or NTD control plan. The plan should also give details of the national supply chain and programme financing (budget and funding sources). The eligibility criteria for donation will include the WHO recommendation that treatment is warranted when there is a district-level prevalence of follicular trachomatous inflammation (TF) of >10% in children aged 1–9 years. New applications must be received by March for donations for the following year. The process will include an audited trial shipment of a small amount of the drug to test the supply chain.

A specific application, indicating district-by-district needs, should be completed for azithromycin for use after TT surgery.

The current WHO recommendation is to conduct an impact survey after three rounds of azithromycin treatment. The picture is clearly quite complex and trachoma resurgence can occur after discontinuation of treatment. In December 2009, the Trachoma Expert Committee considered evidence in this regard and concluded that for districts with a TF baseline prevalence of $\geq 40\%$ an impact survey could be delayed until five rounds of azithromycin treatment have been completed, to avoid unnecessary expense. For districts with a baseline prevalence of 15–39% impact surveys should be conducted after three to five years, depending on the local situation; and for those with a baseline prevalence of 10–15%, after three years. Once impact surveys, preferably by robust random cluster sampling, indicate that district prevalence has fallen to 5–9%, distribution of antibiotics will be continued in the community, but no recommendations on how that might be pursued have been

established. ITI will approach the possibility of further donations on a case-by-case basis. Coverage will be an important factor; in many cases, local intelligence can indicate the communities where further intervention is warranted. ITI wishes to remain flexible: however, it is for WHO to establish appropriate guidelines.

As indicated previously, the scale-up needs towards the GET 2020 target are considerable. In the first 10 years of the global programme, there has been a rise in the number of countries receiving azithromycin from two to 19 and in annual treatments from around 700 000 to a projected 53 million for 2010. The next couple of years will see the addition of a further 23 countries and an increase to 80 million annual treatments. The picture is complicated by the lack of infrastructure and resources in the remaining endemic countries, many of which are in or emerging from conflict, and by the need to take account of, and hopefully benefit from, the rapid expansion of NTD programmes. ITI is considering ways to accelerate mapping.

Planned ITI shipments (and their value) for 2009 and 2010 total 40 million treatments (US\$ 994 million) and 48 million treatments (US\$ 1144 million), respectively. Some 80% of 2009 shipments went to five countries: Ethiopia (42%), Mali (13%), Niger (10%), United Republic of Tanzania (8%) and Burkina Faso (8%). Pfizer has donated nearly 190 million treatments since the start of the programme.

6. NTDs: report on ongoing programmes, links with trachoma elimination, action and resources development

Dr Albis Francesco Gabrielli, Medical Officer, Preventive Chemotherapy and Transmission Control, Neglected Tropical Diseases, Geneva, Switzerland

Neglected tropical diseases cause significant morbidity and mortality in the poorest groups within populations and represent a cumulative disease burden (56.6 million disability-adjusted life years, DALYs) that is higher than that of malaria or tuberculosis. They are all associated with factors characteristic of poverty, including poor access to safe water, sanitation and essential medicines. While strategies to combat these diseases are diverse, preventive chemotherapy is available through single-dose mass administration of safe and effective drugs that are inexpensive or donated for the control of lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminths and trachoma. Moreover, the F and E components of the SAFE strategy used for trachoma control are also of benefit in tackling the other diseases.

Integration can take place at different levels within countries. At the policy level, the same ministry of health staff are often involved in planning and budgeting for control activities for the different NTDs. Integrated plans and budgets can result in a higher profile for these activities, which increases the likelihood of resource mobilization. Integration at the implementation level can include coordinated forecasting of drug needs and procurement, sharing of drug delivery channels, even though the different drugs are not distributed at the same time, coordination of health education to promote behavioural change, and sharing of resources and facilities for morbidity and disability management. It is also useful to coordinate mapping, monitoring and evaluation activities. All the programme managers responsible for the target diseases should be involved in planning and implementation. The goal of integration is to develop multi-year national plans of action, tailored to the local situation but prepared in a standard format and using a standard budgeting (gap

analysis) tool, and incorporating scale-up plans. WHO plans to hold annual meetings with countries and all their partners to assess national plans and annual funding cycles, and to monitor implementation progress. Additional technical and strategic meetings may also be needed. As indicated under section 2, WHO is developing a global NTD databank that will include NTD country profiles, with information on trachoma taken from the trachoma data forms.

Integrated plans of action should comprise: a brief country profile; information on epidemiology and control activities for each of the NTDs present; an outline of coordination mechanisms, goals and objectives, implementation strategies and the role of partners; operational recommendations; drug forecasts; logistic information; and a five-year budget indicating total requirements and financial shortfalls.

WHO is coordinating action within the Organization in order to serve Member States in the best way possible. It has already provided support for integrated control of NTDs to a number of countries. In Nepal, for example, there was a joint United States Agency for International Development (USAID)/WHO country visit in May 2009 to assess the interest of the Ministry of Health and the capacity of its technical units. In June–July 2009, the Ministry developed a national plan of action for the integrated control of NTDs with support from WHO. The plan shows the activities that have already been implemented and the funding gaps. A stakeholder meeting was organized in Kathmandu in December 2009 to discuss the plan and to present it to potential donors, and in January 2010 the plan was approved and funded by USAID. The national trachoma control manager was fully involved in this process.

7. Reports from selected countries

Southern Sudan

*Dr L. Kur, National Coordinator, Trachoma Control, Ministry of Health,
Government of Southern Sudan, Juba, Sudan*

Trachoma remains endemic in 16 counties of Southern Sudan with a population at risk of trachoma totalling around 2.8 million. The target date for elimination of blinding trachoma is 2020. Trachoma control activities using the SAFE strategy started in 2001. A national trachoma control programme office was established in the Ministry of Health in 2007 and a trachoma control task force was set up in 2009.

Highlights in 2009 included the second annual trachoma control programme review, expansion of antibiotic distribution, completion of two trachoma rapid assessments, and development of a Southern Sudan trachoma risk map.

Prevalence of TF in children aged 1–9 years remains high (>30%) in a number of counties, and there are still areas where TT in adults aged ≥ 15 years is >10%. The UIG for surgery is >73 000 but so far, despite training of 26 surgeons, the cumulative total is just 14 000 and only 1558 surgeries were performed in 2009. Further efforts are needed to strengthen surgery camps, equip hospitals in endemic areas, and provide better education on TT to promote surgery uptake.

Antibiotic treatment is distributed from centres chosen by community leaders and involves local government and institutions from the initial planning stages. Distribution is accompanied by simple health education messages in local languages.

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Antibiotic distribution is being expanded and some counties are already on the fourth round. Taking account only of surveyed counties, the projected UIG for antibiotics is 2.8 million treatments. The cumulative total by 2009 was 1.7 million, with 370 431 added in that year.

Health education materials on trachoma are being prepared, but community and school health education reaches only a small proportion of the population and expansion in this area is slow.

Efforts are under way to promote the construction and proper use of latrines using the community-led total sanitation (CLTS) approach. New partners are needed to support activities to improve water supplies and sanitation.

The epidemiological situation is not known in >40 counties in the 10 states of Southern Sudan and SAFE implementation does not yet cover all the population at risk, even in the counties surveyed. Resource constraints remain an obstacle to the achievement of UIGs, and new partners are sought. AIOs for 2010 have been set and baseline prevalence surveys in 21 counties are planned. It is hoped that county-level impact surveys in counties where there have been 4–5 rounds of mass drug administration can be conducted in 2011, if funds allow.

Thanks are due to all partners and donors including: the Bright Horizons Foundation for Children, the Carter Center, Christian Blind Mission, Christian Mission Aid, the Conrad N. Hilton Foundation, Foundation Dark and Light, Dr and Mrs Hussman, ITI, the Malaria Consortium, the National Democratic Institute for International Affairs, Pfizer Inc., Sight Savers International, UNICEF, USAID and WHO.

Mauritania

Dr A. Ould Minnih, Coordinator, National Programme for the Prevention of Blindness, Ministry of Health and Social Affairs, Nouakchott, Mauritania

The first national survey, conducted in 2000, showed TF prevalence ranging from 8.4% to 24.9%, with an average of around 15%. The prevalence was highest in the north of the country. TT prevalence averaged 0.24% and again was highest in the north. However, this survey was not very precise.

Further surveys were conducted, by county, in 10 of the 13 regions in 2004–2005; the final three regions will be surveyed in May 2010. In the surveys already conducted, TF prevalence ranged from 0.29% to 25.6% in regions and 1.6% to 34.7% in counties. Regional TT prevalence ranged from 0 to 0.70%.

The national trachoma control programme adopted the SAFE strategy and implementation of the S and A components commenced in 2005. Activities are being scaled up gradually to cover the whole country. Three surgery trainers were trained who in turn trained 26 surgeon, and surgery kits and consumables were procured. TT surgery is offered free of charge and mobile campaigns have been conducted in six regions. To date >900 operations have been performed. TT cases were detected through mobile campaigns. However, this proved costly for the few cases found, so health workers have now been trained to detect and refer cases. Cases are also detected during cataract control activities.

The mass drug administration campaigns are complemented by awareness-raising activities during distribution, and by radio and television programmes on eye diseases and trachoma prevention. Between 2004 and 2008, 720 000 people were

treated in 19 counties where TF was $\geq 10\%$, in seven regions. Treatment was given house-to-house in three rounds and coverage was $>85\%$ (75–93%). Efforts are also being made to improve safe drinking-water supplies in endemic regions.

An impact survey conducted in 2009 after three rounds of antibiotic treatment showed that TF prevalence rates had declined substantially in most areas, although in one it had risen to 26.4% and there were pockets where a high rate persisted. Additional treatment and retreatment campaigns are planned for the period 2008–2011.

Partners include Lions Club International Foundation (TT surveys and surgery), Fondation Bouamatou (mass antibiotic treatments, purchase of tetracycline ointment, impact surveys) and ITI (surveys and supply of azithromycin).

Ethiopia

*Mrs E.B. Habtemariam, Pastoralists Health Promotion and Diseases
Prevention Directorate, Federal Ministry of Health, Addis Ababa, Ethiopia*

In a survey published in 2007, the prevalence of active trachoma (TF + TI) was shown to range from 0.5% to 62.6%; the current national prevalence is 40.41%. The national prevalence of TT is 3.1%.

To coordinate control activities, the Ministry of Health has established national, regional and local committees for the prevention of blindness, and a national committee for trachoma control. A mid-term review in 2009 of the second national strategic plan for trachoma control (2006–2010) indicated that further efforts were

needed if targets were to be reached. Antibiotic coverage is particularly low in areas where security is a problem and it is difficult to reach and mobilize communities. The third national strategic plan is in preparation.

A national survey on blindness, low vision and trachoma was conducted 2006, and guidelines for antibiotic distribution and a primary eye care manual for health extension workers have been prepared and disseminated.

In 2009, 81 771 of the planned 237 374 TT surgeries were performed, compared with 70 868 of 177 354 in 2008. Distribution of antibiotics was achieved in 155 districts of the 174 planned, compared with 124 of the 157 planned in 2008, and the number of azithromycin treatments was 15.7 million of the 26.7 million planned, compared with 14.8 million of the 22.7 million planned in 2008. There is ongoing national and Ministry of Health commitment to meet the Millennium Development Goals, in particular, to increase sustainable access to safe drinking-water by 2015 by 50% and to scale up environmental improvements and health education.

Ethiopia has strong plans in place and good partnerships, with coordination between nongovernmental organizations and other development partners to avoid duplication of effort. It also has a network of 30 000 health extension workers and there is increased community awareness and participation in primary health care and primary eye care. However, there are still financial constraints, including a major shortfall for antibiotic distribution of US\$ 24 000 per district and of human resources trained in ophthalmology. The supply of kits and consumables for TT surgery is also inadequate.

Burkina Faso

Dr Bernadette Yoda, Coordinator, National Programme for the Prevention of Blindness, Ministry of Health, Ouagadougou, Burkina Faso

Trachoma remains an important public health problem in Burkina Faso and is the second cause of preventable blindness after cataract. The national programme for the prevention of blindness has mapped trachoma prevalence in 59 of the 63 health districts since 2005. Prevalence of TF in children aged 1–9 years ranges from 0.51% to 20.96% and is $\geq 10\%$ in 25 districts. TT in adults aged >15 years ranges from 0.12% to 2.31%. It is hoped that mapping will be completed in 2010. Burkina Faso is implementing the SAFE strategy.

Between 2001 and 2004, around 3000 TT surgeries were performed at health centres; an estimated 23 000 persons still require surgery. Plans to intensify this aspect of the programme have been submitted to partners but financing has so far not been forthcoming.

Mass treatment with azithromycin donated by Pfizer through ITI has started in districts with a TF prevalence of $\geq 10\%$. Planned distribution of three annual rounds is managed in the context of an integrated programme for the control of NTDs. The numbers treated have risen from 1.2 million in three districts in 2007 to a projected 3.4 million in 15 districts in 2010. However, movement of populations is an obstacle to high coverage. It is hoped to conduct an impact survey in seven districts during 2010. It is not certain whether funding will be available to undertake a fourth round of treatment in those districts before the survey is completed.

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The Ministry of Health Directorate for Public Hygiene and Health Education and the Ministry of Agriculture have been charged with developing F and E activities but as yet there has been no action in this area.

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Guinea

Dr André Goepoguli, Coordinator, National Programme for the Control of Onchocerciasis, Ministry of Public Health, Conakry, Guinea

Preliminary surveys in 2001 and 2002 indicated high prevalences of active trachoma (>20%) and TT. In 2004, training was given to 12 TT surgeons, 147 primary eye-care nurses and 3500 community workers for TT detection. Between 2004 and 2009, 3193 TT surgeries were performed. It is estimated that in the districts surveyed >33 000 surgeries are still required. A small antibiotic treatment campaign was conducted in one district in 2004 where prevalence of active trachoma was >35%; around 26 000 persons in 21 villages were treated with azithromycin, treatment being reinforced by health education and sanitation. The intervention was

supported by Laboratoires Théa and Helen Keller International. A survey one year later showed that prevalence had been reduced to <10%.

Guinea is hoping to eliminate blinding trachoma as a public health problem by 2018. Mass treatment will start in 2011 in the 10 health districts surveyed in 2001. The districts surveyed using a trachoma rapid assessment in 2002 will be resurveyed, and treatment will start there in 2012. The programme will be scaled up to cover the whole country with at least five rounds of treatment in each district by 2018. Projected numbers of treatment will rise from 6 million in 2011 to around 21 million in 2015. Antibiotic allocations for 2011 and 2012 have already been approved.

Political instability, which entails frequent changes of ministers and the reallocation of health workers to different locations, is a major challenge for the country and for partners. Limited government resources are allocated to health and non-fatal NTDs are not considered to be a priority; even promised funds sometimes fail to appear. Geographical factors and lack of training are also major obstacles.

Partners include the Centre for Neglected Tropical Diseases, Liverpool, Helen Keller International, ITI, Organisation de la Prévention de la Cécité, Plan Guinea, Sight Savers International, USAID and WHO.

Central African Republic

Dr Georges Yaya, Director, National Programme for the Control of Blinding Diseases, Bangui, Central African Republic

A randomized trachoma prevalence survey was undertaken in May–June 2008 with the support of WHO and Pasteur Institute, Bangui in 22 villages in eight

districts; 1250 children (<9 years) and 1200 adults (>15 years) were examined. Active trachoma was present in four villages in the forested part of the country, with TF prevalence ranging from 14.0% to 26.7%. The findings were consistent with those obtained with conjunctival swabs. TT/corneal opacity was found in five villages; prevalence was 2–4%. However, many areas of the country have not yet been surveyed owing to lack of funds, difficulty of access and security problems.

The SAFE strategy has been integrated in the national trachoma control programme. However, mass treatment with azithromycin has not started, as there are insufficient supplies of the drug. Tetracycline ointment is available on prescription, which patients have to pay for. TT surgery is undertaken in health facilities but again patients must cover the costs.

Awareness-raising campaigns have been undertaken in schools and communities to improve facial cleanliness. The European Union and the United States Peace Corps are providing support for well-drilling, and latrine construction and use programmes, respectively.

Gambia

Mr Ansumana Sillah, Manager, National Eye Care Programme, Ministry of Health, Banjul, Gambia

In the 1960s, when trachoma prevalence was up to 60% in many communities, investigations were undertaken to determine whether it would be possible to develop a vaccine against the disease. National epidemiological surveys conducted in 1986,

1996 and 2006 indicated that active trachoma prevalence was 16.1%, 7.2% and 10.6%, respectively, in children aged 0–9 years. The 2006 survey indicated that village prevalence ranged from 0 to 40%.

Gambia is implementing the SAFE strategy with the support of ITI, Johns Hopkins University, London School of Hygiene and Tropical Medicine/medical Research Council, Pfizer Inc., Sight Savers International and WHO (surveys and human resources development). However, aggressive information and education campaigns have been needed to mobilize communities sufficiently to accept SAFE activities and to change their behaviour. Operational research is continuing, with the help of partners, to guide planning.

The 1996 survey revealed a total of 10 400 people with TT. This backlog has now been cleared, but further case detection efforts are continuing through trained community members. Surgery is undertaken at home and free of charge.

In communities with a low rate of infection, antibiotic treatment is stopped after the first round and surveillance is carried out every six months to ensure there is no resurgence. Elsewhere, three rounds of treatment are given. Analysis in children aged 0–9 years has revealed the following risk factors: nasal and ocular discharge in children aged 1–5 years (these children have been weaned but are not yet in school); another child in the household with active trachoma; and cross-border population movement, which results in re-infection.

Most communities now live within 30 minutes walk of the nearest water source that is available all year round. Latrine construction, using local designs and materials, is promoted by the Department of Community Development, and coverage is good (>85%). Facial cleanliness is >90% in most communities, although pockets remain, especially close to borders, where levels are not satisfactory.

Recent data suggest that Gambia is on course for elimination of blinding trachoma as a public health problem, since in all four districts prevalence of active trachoma in children aged 0–5 years is <5%. However, further surveys will be needed to validate the data for certification purposes. In order to avoid re-emergence, a detailed surveillance plan to monitor levels of TF and TT was approved by the national trachoma task force in November 2009. It is hoped to launch surveillance activities during the second half of 2010, resources permitting. Guidance is needed on how long surveillance should be maintained and whether azithromycin supplies will be forthcoming if there is a need for retreatment. Gambia has submitted its azithromycin requirements to ITI. It is unlikely to use all the supplies in stock and has proposed that the excess could be used to support activities in neighbouring countries. Elimination of the disease in the entire subregion will be an important factor in preventing re-emergence in Gambia the future.

United Republic of Tanzania

Dr B.R. Shilio Mpoki, National Eye Care & Onchocerciasis Control

Programme Ministry of Health and Social Welfare, Dar-es-salaam, United Republic of Tanzania

Trachoma control activities started in 1970 and were strengthened with the introduction of the SAFE strategy and mass treatment with azithromycin in 1999 thanks to the support of ITI and other eye-care partners. The programme has been extended from six districts in 1999 to 54 districts in 2008. The 2004–2008 five-year

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strategic plan incorporates strategic objectives for attaining the GET 2020 goal. Most activities are directed from the district level with central advocacy and financial support to cover gaps after the withdrawal of a major partner.

Baseline surveys conducted from 2004 to 2006 indicated an average prevalence of active trachoma of 25.4%, with a range up to 64%. Prevalence of TT was 2.7 %, with a range up to >10%; there is a backlog of 167 000 cases requiring surgery. Cases are detected and treated through outreach visits and camps. However, the 205 surgeons are not well distributed and are not all active, and only 17 231 surgeries have been performed since the survey.

Mass drug administration has not been systematic in most districts since 2006. Although some districts have conducted three rounds these have not been at regular intervals or reached the minimum recommended coverage, so that further rounds are required. Distribution is scheduled in 28 districts in 2010 if the plan is approved.

Health education is provided in schools and by radio and televisions, but there is a need to scale up activities to all endemic districts. Partners for improvement of the environment are not dealt with directly by the health sector.

An integrated plan for control of NTDs, including trachoma, is under development. Trachoma will therefore be addressed through the national NTD task force and the national prevention of blindness committee. However, there is no plan currently in place for trachoma control. Furthermore, no azithromycin allocation has been approved for 2010 since funds are not available to conduct the required drug audit. It is therefore difficult to generate partner support.

Financial constraints remain a major challenge. As a result, mass drug treatment is not being implemented systematically and district-level reporting is irregular. TT surgery and post-operative follow-up rates remain low. Human

resources have declined following the reallocation of staff to other programmes. Lack of funds also prevents the conduct of impact surveys in the 14 districts where these are required. As eight of these had a high baseline prevalence (>28%), further treatment might be needed.

Partners include: for TT surgery, Helen Keller International, Kilimanjaro Christian Medical Centre, Christian Blind Mission, Lions Clubs International, Sight Savers International and University College of Mohambili; for antibiotic treatment, ITI; for environmental improvement, Helen Keller International, UNICEF, WaterAid and the World Bank.

Zambia

*Dr D. Kwendakwema, Secretary, National Programme for Blindness Control,
Ministry of Health, Ndola, Zambia*

A trachoma prevalence survey was undertaken in 2007 and 2008 with the support of the Ministry of Health, Operation Eyesight Universal and Sight Savers International in five selected districts. Prevalences were as follows: TF in children aged 1–9 years, 9.7–32.7%; dirty faces, 51.0–74% (younger children had fewer dirty faces); and TT in adults aged >15 years, 0.1–1.5%. A total of >3500 cases required surgery.

The Zambian Government has made a commitment to GET 2020 through implementation of the SAFE strategy, and has developed an ambitious 2011–2013 national trachoma plan. There is also an NTD control programme. It has revived the

national committee for the prevention of blindness, and established the post of national eye-care coordinator; a national trachoma task force is in place and district task force membership is being identified. Only five of 72 districts have been surveyed to date owing to the high cost (US\$ 40 000 per district), which is partly related to high per diem costs for staff and to the large sample sizes. Efforts to engage the mining companies and other potential partners are under way, and ITI is willing to help with advocacy. The Zambian Ophthalmological Society, due to be launched in May 2010, should provide a useful forum in which to raise the profile of trachoma. Presidential and parliamentary elections are due in 2012, which gives rise to political uncertainties.

8. Reports from international partners

Pfizer Inc.

Ms L. Foster, Senior Director, Corporate Responsibility, Pfizer Inc., New York, NY, USA

Pfizer Inc. has undergone a number of changes in the past few years and recently merged with Wyeth, so that it now produces products for every stage of life over a wide range of fields and has a large research and development capacity. It has 75 manufacturing sites worldwide and sales in 150 countries, and in 2009 made philanthropic investments of US\$ 2.4 billion.

Pfizer is collaborating with the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR). It is providing access to its library of medicinal compounds, with an initial focus on those with anti-parasitic properties, and is training scientists from developing countries in drug discovery techniques as part of its efforts to speed the search for new drugs. Developing country researchers, supported by the TDR Medicinal Chemistry Network, work with Pfizer scientists to evaluate potentially useful compounds and select leading candidates for further research.

Pfizer is also collaborating with more than 1000 partner organizations on eight major global health programmes designed to improve people's access to medicines and build capacity in existing health delivery systems. It helped to establish the Infectious Diseases Institute, a regional training, research and treatment centre based at Uganda's Makerere University School of Medicine, which opened in 2004. To date, the Institute has trained more than 4200 health-care workers from 27 African countries. The Global Health Fellows programme sends fellows to work in the field with local and nongovernmental organizations. Since 2003, 232 fellows have worked in 39 countries and six fellows have worked with ITI. Pfizer is also providing US\$ 15 million over five years (2007–2012) to help close critical gaps in malaria treatment and education in Kenya, Ghana and Senegal; US\$ 47 million over three years to support cancer and tobacco control efforts across the world; and the donation of fluconazole (Diflucan®) to 63 developing countries to treat fungal opportunistic infections associated with AIDS.

Pfizer is a founding member of ITI and has so far provided some 190 million treatments of azithromycin through ITI for the elimination of blinding trachoma in 18 countries. It is also supporting TT surgery and advocating the full implementation of

the SAFE strategy. In 2009, support in medicines and funding totalled almost US\$ 1 billion. ITI forecasts indicate that the number of treatments will have to double from 39 million in 2009 to around 78 million in 2015 if the GET 2020 goal is to be attained. Pfizer therefore needs accurate planning and forecasting to be able to scale up azithromycin manufacture in due time. It will collaborate with ITI to facilitate the coordination of drug application and supply chain procedures for the integrated control of NTDs.

Pfizer remains committed to the elimination goal and is encouraged by the progress made, in particular, in Morocco, Gambia, Ghana and Viet Nam, and by the momentum generated developments in the integrated control of NTDs.

Discussion

The meeting welcomed the renewed commitment by Pfizer to the provision of azithromycin within the SAFE strategy and to its support for education and training through the Infectious Diseases Institute and the Global Health Fellows programme.

Laboratoires Théa

Dr S. Resnikoff, Director, Laboratoires Théa, Clermont-Ferrand, France

Laboratoires Théa is an independent group, owned by the Chibret family, specializing in ophthalmic drugs and devices. Based in France, the company has subsidiaries across Europe and works with partners across the world, including Pfizer: 90% of its manufacturing is outsourced. Laboratoires Théa is only 15 years old;

however, the Chibret family has had a long-standing interest in ophthalmology and eye care education over four generations. It was instrumental in founding the French Society of Ophthalmology in 1883, and established the Chibret medal, awarded in alternate years to a French and German ophthalmologist. In the 1950s and 1960s, it was associated with trachoma control activities in North Africa and since the 1990s, through its Foundation, has supported African Institute of Ophthalmology (IOTA) scholarships, and epidemiological surveys in nine countries in West Africa.

Since 1998, the company has been working to develop an azithromycin formulation for topical administration as eye drops. Since 2008, this formulation (Azyter) has been authorized for use in trachoma and bacterial conjunctivitis and has been shown to reduce active trachoma (TF/TI) in a field trial in Cameroon. It is a heat-stable oil-based formulation applied using a single-use dropper (containing six drops) at a dose of two drops, twice a day for three days.

Laboratoires Théa is eager to contribute to the global elimination of blinding trachoma through donation (in specific cases), special pricing or not-for-profit provision of the formulation, which should prove useful for the treatment of pregnant women and young children and in areas where pockets of trachoma persist after mass antibiotic treatments.

Discussion

Participants paid tribute to the Chibret family for their role in combating trachoma and supporting IOTA scholarships, and encouraged the company and its business partners to see how the potential of the eye-drop formulation could be realized.

Further operational research is needed to determine whether the formulation is suitable for administration by mothers without risk of cross-contamination through drawback into the dropper used, and to compare its cost-effectiveness with tetracycline ointment. Scientific information on the formulation should be distributed to national trachoma control programme managers.

9. Reaching elimination of blinding trachoma by 2020

Countries' perspective

In addition to the comments made by country representatives in their reports to the meeting (see section 7), the representatives of Ghana, India, Morocco, Senegal, and Viet Nam, who participated in the discussion by teleconference, outlined their obstacles to and needs for achieving GET 2020. The representatives of Mali and Nigeria made additional contributions.

General needs

Many endemic countries are developing, low-income countries experiencing financial and human resource shortages. Some have geographical and logistic difficulties. Political instability and lack of commitment are obstacles to effective trachoma control activities. Health and trachoma control are not always perceived as a high priority; government allocations need to be increased and delivered on time. Funding for training and capacity-building should also be increased. Some countries

are in or emerging from conflict, giving rise to security concerns. Further efforts to achieve the Millennium Development Goals would also benefit trachoma control.

Most countries have established national trachoma control task forces and coordination with other state sectors and partners is improving, but there is a need to engage new partners and develop a more even distribution of partner support.

Countries need support and capacity-building to ensure systematic data collection; reliable information is essential to guide planning and implementation of trachoma control activities. South-south technical cooperation should be facilitated so that endemic countries can learn from one another.

Surveys

Many countries require additional support to complete surveying across their entire territory because they find the costs of conducting baseline trachoma prevalence and impact surveys are high and they do not have the necessary capacity. There is also some uncertainty over the best type of survey to use, and the appropriate timing and sample size. WHO is requested to issue clear guidelines on recommended survey techniques.

TT surgery

Guidance is needed on how to tackle the large backlog of TT cases requiring surgery in many countries. Few countries are achieving their AIOs despite training additional surgeons, and scale-up is very slow. Case detection is proving costly for large countries with a widespread population, although training of community health workers to detect and refer cases has been shown to improve the situation. There are shortages of surgical kits and consumables.

Antibiotic treatment

For most countries, logistic difficulties and operational costs for antibiotic distribution represent a major obstacle and have sometimes led to inadequate coverage or the interruption of treatment, leading to a resurgence in active trachoma. Some countries find that coverage is not high in the first round because community awareness is low. Further technical guidance is needed on how many rounds to conduct, and how to time impact surveys. Cross-border collaboration is needed to reduce the risk of re-infection through population movement to and from neighbouring endemic countries.

Guidance is needed to support countries in coping with the changes in the application procedure for donation of azithromycin through ITI.

Facial cleanliness and environmental improvement

Many countries need further support in order to establish and expand activities in these areas but find it difficult to secure partners, especially for water supply and sanitation improvements. They acknowledge the need to improve coordination with the other government sectors involved. Health education activities require expansion in order to improve community awareness about trachoma and encourage changes in behaviour.

Surveillance

Countries approaching elimination of blinding trachoma need guidance on how to set up and maintain surveillance programmes. They also need support and capacity-building for this activity.

Certification of elimination of blinding trachoma

Countries that have achieved or are about to achieve their UIGs require guidance on the proposed certification procedures and request WHO to finalize the procedures as soon as possible.

Integrated control of NTDs including trachoma

Countries require support during the transition to planning and implementation of national integrated NTD control programmes that incorporate the full SAFE strategy for trachoma control activities; it is crucial to ensure that there is no interruption to azithromycin treatment rounds in trachoma-endemic areas.

Partners' perspective

General needs

The partners recognized the needs and obstacles articulated by country representatives.

In the next few years, special efforts must be focused on endemic countries that are not yet engaged or are lagging behind in progress towards GET 2020.

Alliance partners are aware of the countries concerned and should play their part in encouraging engagement. Planning must aim for implementation of the SAFE strategy in every endemic district by 2015. Global estimates of the current situation are needed to guide the process.

Although funding prospects for trachoma control are generally optimistic, despite the current global economic situation, the scale-up needs are considerable and further analysis is required to identify major funding gaps.

Partner support is needed to help countries improve national planning. National trachoma control plans, which may be incorporated within plans for integrated control of NTDs, should be realistic, properly-costed, strategic business plans that include all the SAFE components, plus monitoring and evaluation activities to track progress. They should include clear objectives and indicate needs and responsibilities month by month, and careful thought should be given to the proportion of funding allocated to each component. Moreover, they should be based on needs rather than the resources available and should not be dictated by donors. A tool developed by RTI International/USAID for use in budgeting for NTD programmes might be helpful in supporting countries to prepare trachoma control budgets, although it covers only the A component rather than the full SAFE strategy. National plans should feed into Vision 2020 activities.

Sustained government commitment to trachoma control, and stable government and human resource allocations are necessary to ensure strong country ownership of national plans and effective national trachoma control task forces, and to attract partner support. National programme planning and management capacity should be enhanced through partner support from partners and technical cooperation among developing countries.

Further strengthening of nongovernmental organization and donor cooperation is needed to increase coordination at the international and national levels and to strengthen advocacy at country levels. Dialogue through the Alliance should therefore be maintained, and WHO regional and country offices should also be involved.

There is a need to harmonize policy recommendations, programme indicators and forms for submitting applications for support.

Countries are urged to ensure consistent national representation at Alliance meetings and similar forums to maintain continuity in discussions. Future country reports at Alliance meetings should focus on GET 2020 needs and obstacles.

Surveys

Further research is needed to refine recommendations for initial and impact survey procedures, with different models that can be tailored to individual country situations. It was suggested that consideration of revised guidelines should be included on the agenda of the Third Global Scientific Meeting on Trachoma in July 2010.

The cost of surveys can be reduced by developing small experienced teams that can work faster, by carrying out surveys that include a number of districts, for economies of scale, and by seeking partner funding for infrastructure support, for example transportation.

Trichiasis surgery

The backlog of TT surgery is a major obstacle to the achievement of GET 2020. Countries and partners must give this aspect greater priority, and further research is needed to gain a better understanding of why progress has been so slow.

Quality of surgery is vital to ensure successful outcomes: production and dissemination of a card, similar to the active trachoma grading card, to show what the eyelid should like after surgery is being planned.

Antibiotic treatment

Antibiotic treatment should be continued pending the results of impact surveys, at least in the worst districts, in order to avoid any resurgence in trachoma. National programmes and their partners should ensure that planning takes this into account.

Facial cleanliness and environmental improvement

Sustained socioeconomic development should lead to improvements in these components. Nevertheless, countries and the Alliance should make greater efforts to involve sectors other than health and new partners in specific F and E activities. The Alliance should help overcome perceptions that these activities are difficult. For example, the community-led total sanitation (CLTS) approach and interventions to integrate trachoma messages into school health programmes are effective and are not expensive.

Surveillance

Countries require guidance on how and for how long to conduct surveillance activities.

Certification of elimination of blinding trachoma

Certification procedures and guidance for completing the certification process should be finalized as soon as possible.

Integrated control of NTDs including trachoma

Some operational difficulties are being experienced in the integrated NTD control programmes currently being implemented in certain countries. These should be acknowledged and discussed openly. It is essential to ensure that equal attention is given to all the diseases concerned, and that all components of the SAFE strategy are incorporated.

It is likely that standardized, multi-disease, integrated plans of action will be the customary resource mobilization tool for NTD implementation in the future. These plans should be tailored to each country's epidemiological situation and administrative structure. Implementation efforts should eventually be incorporated in primary health care, as was the case with immunization – vertical immunization programmes were integrated into the Expanded Programme and then became part of primary health care systems. National coordinators and national trachoma task forces will need to collaborate closely with their counterparts for other NTDs.

Trachoma partners should receive adequate advance notice of relevant meetings on integrated NTD control.

10. Conclusions and recommendations

Conclusions

Despite the severe disruption to air travel over Europe caused by ash clouds following a volcanic eruption in Iceland, 45 participants attended the meeting, some after challenging journeys. The attendance of representatives from Member States was particularly affected. The effort made by all those seeking to attend is commended.

Progress towards the GET 2020 target is consistent but challenges remain, in particular in relation to the expansion of trachoma control activities in large countries and to reaching countries not yet engaged. It is essential to give priority to countries with a large burden for SAFE implementation; however, countries with a smaller burden, those that are achieving elimination and those not yet engaged should not be neglected as they are also key elements in achieving the global target. Updated global estimates are needed to guide future activities and are also essential for advocacy. The meeting agreed that the trachoma data form should be modified to include a request for information on partners involved in activities related to the S and A components; information on partners for F and E is already covered.

There is increasing coordination of trachoma elimination within the neglected tropical disease framework. In order to secure implementation of all components of the SAFE strategy, ongoing advocacy is essential. Participants noted that Alliance members, Member States and international partners, are currently undertaking advocacy in the appropriate forums.

National trachoma elimination coordinators should give priority to participating in work on neglected tropical diseases, including attendance at regional and national meetings, to ensure that the SAFE strategy is included. Information on regional and national meetings on neglected tropical diseases should be disseminated through the Alliance to allow interested partners to attend where possible and to help in supporting SAFE in neglected tropical disease workplans.

Recommendations

1. The WHO Secretariat should ensure that the agenda of meetings of the Global Alliance for the Elimination of Blinding Trachoma includes a review of the

progress made in implementing the recommendations made at the previous meeting

2. Collection of data on the trachoma burden and SAFE implementation is essential to monitor progress towards ultimate intervention goals.
 - (a) WHO is requested to facilitate the harmonization of different data-gathering forms
 - (b) National trachoma task forces and partners of national trachoma elimination programmes should contribute in providing data.
 - (c) There is a need for a global database, accessible to all stakeholders including Members States and partners, in which data and plans from Alliance members are made available.
3. Many countries are soliciting to be certified as having eliminated blinding trachoma. WHO is requested to finalize the certification criteria as soon as possible and present them at the next Alliance meeting; and to engage in discussion with countries and WHO country offices on the work needed for certification.
4. Global leadership to clearly define processes, thresholds and targets is crucial for achieving the global elimination of blinding trachoma.
 - (a) The Third Global Scientific Meeting on Trachoma, should define technical requirements for trachoma surveys, treatment and surveillance to be applied by all Alliance members.
 - (b) At the national level, Government leadership and the role of national trachoma task forces should be supported by all partners.

5. With only ten years left to achieve the GET2020 goal, it is essential that countries, together with partners, develop or revisit their national trachoma elimination plans and estimated costs for their implementation.
 - (a) The plans should be submitted in good time to permit the preparation of a progress report for presentation to the Fifteenth Meeting of the Alliance in 2011.
 - (b) The plans should contain annual goals and budgets for achieving ultimate intervention goals in each of the next five years through implementation of the full SAFE strategy, so that sufficient funds can be mobilized.
 - (c) A trachoma action plan template will be developed by the International Trachoma Initiative, for distribution by the Alliance, within the next two months.
 - (d) WHO is requested to set up an executive committee to review the proposed trachoma action plan template before submission to national authorities for completion, recognizing that the data are required for global advocacy by August 2010.
6. The Secretariat is requested to set up an executive committee to oversee the Technical Scientific Informal Workshop, to set criteria, to review and select research for discussion and to set dates for abstract submission. Presenters and non-presenters will be notified at least one month prior to Workshop meetings. Alliance members should be invited to attend meetings, although support for their participation may not be available.

7. National representatives, nongovernmental organizations and other Alliance members are encouraged to identify key operational problems that require research attention and capacity-building and to raise them at Alliance meetings.
8. Updated global epidemiological estimates on trachoma, confirmed by the relevant countries are important for advocacy. The Alliance should support the preparation of such estimates.
9. WHO and GET2020 Alliance members should provide technical and managerial support as appropriate and through technical cooperation among developing countries (TCDC).
10. Member States should seek to demonstrate their commitment by maintaining continuity in national coordinator representation at Alliance meetings and within national trachoma elimination programmes.

11. Date and place of the next meeting

It was agreed that the Fifteenth Meeting of the Global Alliance for the Elimination of Blinding Trachoma should take place in April 2011, at WHO headquarters, Geneva.

Annex 1. Agenda, and scope and purpose of the meeting

Agenda

Introduction

- Introduction of participants
- Nomination of officers
- Administrative announcements
- Adoption of agenda
- Opening statements

Agenda item 1: Review of trachoma data forms

Agenda item 2: Report of the International Coalition for Trachoma Control

Agenda item 3: Report of the Trachoma Informal Scientific Workshop 2010

Agenda Item 4: Azithromycin donation: report from the International Trachoma Initiative

Agenda Item 5: NTD: report on ongoing programmes, links with trachoma elimination, action and resources development

Agenda Item 6: Trachoma control report: Sudan, Mauritania and Ethiopia

New members introduction and partners' report

Agenda item 8: Reports from selected countries and international partners

Agenda item 7: Reaching elimination by 2020:

- Countries' perspective
- Partners' perspective

Conclusions and recommendations

Date and place of next meeting

Closure

Scope and purpose

The purpose of the annual meeting of the WHO Alliance for the Global Elimination of Blinding Trachoma by the year 2020 (GET 2020) is to monitor progress towards elimination at global level, exchange information and experience on SAFE strategy implementation, review the partnership opportunities at global and national level, and discuss obstacles and barriers to the achievement of the common goal, i.e. the elimination of blindness from trachoma by the year 2020.

The Fourteenth Meeting is expected to provide these opportunities and specifically to allow discussion of:

- recent development in terms of SAFE implementation in endemic countries: methods, results, ultimate intervention goals (UIGs) and annual intervention objectives (AIOs)
- opportunities offered by the national neglected tropical diseases (NTDs) framework, with particular reference to the challenge of integrating the surgical and educational components of SAFE;
- surveillance in post-endemic country areas: report from the countries implementing surveillance or about to start implementing it;
- report from WHO and nongovernmental organizations on work in the NTD framework and eye health areas of work.

Progress reports on the implementation of the SAFE strategy and activities to meet the AIOs, prepared in collaboration with all the national stakeholders, will be submitted by country representatives to the WHO Secretariat for presentation at the meeting.

Results from recent evaluations and lessons learnt will be presented to provide an opportunity for countries and partners to discuss further.

Updates on ongoing research projects and recent research findings on the SAFE strategy will also be presented.

Additional objectives of this meeting are:

- to introduce new members of the WHO Alliance for GET2020
- to review the progress made in the development of partnerships and resource mobilization opportunities at global, regional and national levels.

Expected outcomes of the meeting are:

- global monitoring of progress towards the elimination of blinding trachoma
- improved coordination among the WHO GET2020 Alliance partners
- exchange of information on SAFE implementation at national level
- report of the meeting to share progress towards WHA51.11 with all endemic countries and partners.

Annex 2. List of participants

Mr S. Bush, Director of African Alliances and Advocacy, Sight Savers International, Accra, Ghana (*Vice-Chairman*)

Ms L. Cherry, Operation Eyesight, Calgary, Alberta, Canada

Ms E. Cromwell, Assistant Director, Trachoma Control Program, The Carter Center, Atlanta, GA, USA

Professor D. Dean, Senior scientist, Children's Hospital Oakland Research Institute, Oakland, CA, USA

Dr P. Emerson, Director, Trachoma Control Program, The Carter Center, Atlanta, GA, USA

Dr P. Goldschmidt, Hospital Practitioner, Centre Hospitalier National d'Ophthalmologie des Quinze-Vingts, Paris, France

Ms E. Gower, Wilmer Eye Institute at Johns Hopkins, Baltimore, MD, USA

Dr D. Haddad, Director, International Trachoma Initiative, The Task Force for Child Survival and Development, Decatur, GA, USA

Ms E. Heck, Helen Keller International, New York, NY, USA

Mrs P.J. Hooper, Research Project Manager, Lymphatic Filariasis Support Center and International Trachoma Initiative, The Task Force for Global Health, Decatur, GA, USA

Mr J. King, The Carter Center, Atlanta, GA, USA

Dr M. Kollmann, Christian Blind Mission, Bensheim, Germany

Mr C. MacArthur, Director of NTD Control, Training and Community Education, Helen Keller International, New York, NY, USA

Mr G. Minder, Past President Rotary Club Ferney-Voltaire, Geneva, Switzerland

Mr A. Mosher, Assistant Director, Trachoma Control Program, The Carter Center, Atlanta, GA, USA

Ms B. Muñoz, The Wilmer Eye Institute at Johns Hopkins, Baltimore, MD, USA

Dr A.D. Negrel, Organization for the Prevention of Blindness, Paris, France

Ms L. Rotondo, Associate Director, International Trachoma Initiative, Task Force for Global Health, Decatur, GA, USA

Ms E. Shutes, Program Officer, Bill & Melinda Gates Foundation, Seattle, WA, USA

Ms V. Singletary, Supply Chain Manager, International Trachoma Initiative, Task Force for Global Health, Decatur, GA, USA

Ms K. Stalonas, ORBIS International,

Professor H. Taylor, Professor of Ophthalmology, University of Melbourne, Carlton, Victoria, Australia

Professor S. West, Professor of Ophthalmology & Epidemiology, Dana Center for Preventive Ophthalmology, The Wilmer Eye Institute at Johns Hopkins, Baltimore, MD, USA

Mr Y. Zhang, Helen Keller International, Regional Office for Africa, Dakar-Yoff, Senegal

National representatives¹

Dr S. Bamani, Coordinator, National Programme for the Prevention of Blindness, Ministry of Health, Bamako, Mali

Mr S. Commar, Permanent Representative of Australia to the United Nations Office and Other International Organizations at Geneva, Geneva, Switzerland

Dr A. Goepoguli, Coordinator, National Programme for the Control of Onchocerciasis, Ministry of Public Health, Conakry, Guinea

Mrs E.B. Habtemariam, Pastoralists Health Promotion and Diseases Prevention Directorate, Federal Ministry of Health, Addis Ababa, Ethiopia,

Dr R.B. Khandekar, Ophthalmologist, Epidemiologist, Eye & Ear Health Care, Eye Health Care Programme, DAHA, Ministry of Health, Muscat, Oman

Dr L. Kur, National Coordinator, Trachoma Control, Ministry of Health, Government of Southern Sudan, Juba, Sudan

Dr D. Kwendakwema, Secretary, National Programme for Blindness Control, Ministry of Health, Ndola, Zambia

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