

4th Global Scientific Meeting on Trachoma

Background, scope & purpose

Proposed dates: 27–29 November 2018

Proposed location: WHO Headquarters, Geneva, Switzerland

Trachoma is the leading infectious cause of blindness. The World Health Organization has taken a central role in coordinating international efforts to eliminate trachoma as a public health problem, beginning with the first Global Scientific Meeting in June 1996, which considered approaches for global trachoma control, and set the technical framework for the work of the WHO Alliance for the Global Elimination of Trachoma by 2020. In 1998, the World Health Assembly passed resolution 51.11 calling for the elimination of blinding trachoma, and recommending increased activity in support of that goal.

By 2000, it became clear that partners within the Alliance needed technical tools to set goals and monitor progress. National programmes were beginning to implement the SAFE strategy and conduct impact surveys, but lacked international guidance. In addition, a new estimate of the global burden of trachoma was needed in order to plan the work ahead. In response, WHO convened the 2nd Global Scientific Meeting on Trachoma in August 2003.

By 2009, several countries had ceased or were on target to cease antibiotic mass drug administration for trachoma, and a need for further clarification of elimination end points and review of new evidence from operational research was identified. At the request of member states, WHO convened the 3rd Global Scientific Meeting on Trachoma, held in Baltimore in July 2010.

Since then, considerable further progress has been made. Baseline mapping of suspected trachoma-endemic districts has been nearly completed worldwide, and more than half of all districts needing interventions are enrolled as active participants in trachoma elimination programmes. A total of seven countries have been validated as having eliminated trachoma as a public health problem. However, several technical questions have arisen, and a further Global Scientific Meeting is needed to determine whether new evidence should lead to refinement of recommendations made at previous global scientific meetings and consultations, particularly:

- In Melanesia (Fiji, Papua New Guinea, the Solomon Islands, Vanuatu, and islands in the Torres Strait that are part of Australia), there is evidence that moderate to high prevalences of active trachoma in children are accompanied by very low prevalences (or no) trachomatous trichiasis in adults. Considerable research has been undertaken to facilitate better understanding of this phenomenon. Are current definitions of trachoma as a public health problem—and trachoma's elimination as a public health problem—appropriate for the Western Pacific Region, or should they be changed?
- 2. Not all trichiasis is caused by trachoma. Trichiasis can also be caused by blepharitis, Stevens-Johnson syndrome, burns, trauma, tumours, herpes zoster and ocular cicatricial pemphigoid. It is likely that some trichiasis in trachoma-endemic settings is nontrachomatous. For the purposes of defining prevalence targets for "elimination as a public health problem", should diagnosis of trachomatous trichiasis require the presence of trachomatous scarring of the tarsal conjunctiva?
- 3. High-quality trichiasis surgery is critical. How and when should trichiasis surgery outcomes be assessed, and what should the targets be?
- 4. Obtaining precise estimates of the prevalence of very low prevalence conditions is difficult. How should the prevalence of trachomatous trichiasis unknown to the health system be measured for the purposes of establishing that trachoma has been eliminated as a public health problem?