Discrepancies in trachoma control policies and practices in the last decade

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Purpose: To establish the discrepancies in trachoma control policies and practices since 2004

Introduction: The World Health Organisation (WHO) endorses clinical grading for trachoma surveys and SAFE strategy for control: **S**urgery for trachomatous trichiasis (TT), **A**ntibiotics to treat infection and **F**acial cleanliness and **E**nvironmental changes to stop transmission.

Method: Trachoma control guidelines and practices were reviewed. Between 2004 and 2010, interventions were conducted in administrative districts. In 2010, Kenya initiated surveys and interventions in areas (trachoma districts) with 100,000 – 200,000 people each to standardise the intervention units. Later, the WHO recommended impact assessments to be conducted in areas with 100,000-250,000 each. SAFE is implemented where baseline prevalence of active trachoma in children 1-9 years old is $\geq$10%. The lower age limit for surveys and monitoring of TT surgical services varies in different countries. Surgical services are justified where baseline prevalence of TT in persons aged 15+ years old is $\leq$1%. In 2014, the Global Trachoma Mapping Project (GTMP) introduced new guidelines where TT surveys participants are to be recruited exclusively in households sampled for active trachoma survey.

Results: District-based project planning is convenient due to existing administrative structures but trachoma is more of a "community disease" than a "district level disease". As a result, non-endemic communities in large meso-endemic districts (population >200,000 people) were included in mass drug administration (MDA). Also, "hot-spots" in large hypo-endemic districts missed due to widely scattered survey clusters. This triggered the adoption of a new in survey method in 2010. Microbiology tests to verify presence of chlamydial infection and assess drug resistance are not done due to cost and logistics. Prevalence of TT in persons aged 15+ years is usually low and survey sample sizes are big. Researchers adjust TT survey age limit and precision to suit available funds. The GTMP method is convenient but may under-estimate the prevalence since adults with children aged 1-9 years are relatively young while the prevalence increases with advancing age. Results from different surveys will not be directly comparable since the GTMP does not specify the sample size and precision for TT surveys. Moreover, GTM puts emphasis is on SA. Kenya prefers comprehensive surveys to assessment all the components of SAFE. In the last decade, FE components have been perpetually under-funded.

Conclusions: Trachoma policy reviews are influenced by evidence, economic considerations and convenience. FE and trachoma microbiology are vital but ignored. Global trachoma policies should be adopted to accommodate national programme needs.