



Correcting Ten Myths About Eliminating Trachoma

THE FACTS

TRACHOMA IS THE MOST COMMON CAUSE OF INFECTIOUS BLINDNESS WORLDWIDE

Trachoma is caused by specific strains of the bacterium *Chlamydia trachomatis* that causes scarring of the eyelid, inturned eyelashes (trichiasis) and blindness if left untreated.

Trachoma occurs predominantly in developing areas where living conditions are crowded and hygiene practices are poor. Trachoma or "Sandy Blight" disappeared from mainstream Australia 100 years ago.

AUSTRALIA IS THE ONLY DEVELOPED COUNTRY WHERE TRACHOMA STILL EXISTS

Trachoma affects Indigenous populations exclusively and until recently was believed to only affect remote communities.

The National Trachoma Surveillance Reporting Unit and the National Indigenous Eye Health Survey (2009) have found that trachoma remains endemic in almost two thirds of remote Indigenous communities in the NT, SA and WA (and also in some urban settings in other states.)

Blindness from trachoma is entirely preventable and the current suffering, adverse developmental outcomes and productivity losses can be avoided.

A CONCERTED EFFORT IS NOW UNDERWAY IN AUSTRALIA TO ELIMINATE TRACHOMA

The World Health Organization has adopted a resolution to eliminate blinding trachoma by the year 2020.

The Australian government is a signatory to this resolution and has made a commitment to eliminate trachoma. Funds have been invested to expand services and resources.

Public health management of trachoma is now required in a sustained co-ordinated effort across health services, schools and communities.

Some Indigenous communities are successfully reducing trachoma by building a strong awareness of the issues and what people can do to prevent trachoma at a community level.

There are many misconceptions about trachoma and its control, the same questions crop up again and again - its time the myths were dispelled

MYTH # 1

"Trachoma measures will not work."

It is true there have been many attempts at trachoma control in Australia over the last 45 years.

However, none of these programs has fully implemented the SAFE Strategy for a sustained period; they have either only relied on antibiotic distribution to a subset of the community, or they were not sustained, or both.

Evidence from overseas including the desperately poor countries like Tanzania, Ethiopia and the Southern Sudan have shown the effectiveness of the integrated SAFE Strategy over a sustained period. Countries such as Ghana, Mexico, Morocco, Oman and Iran have been able to eliminate trachoma in the last few years.

MYTH # 2

"We do not know enough about the severity and distribution of trachoma." (Or "We need more information before we can act.")

Although it is true that the current data collection can be further strengthened, the current data clearly show that many Indigenous communities have an unacceptable prevalence of trachoma.

Also, although the entire endemic area may not have been delineated and further (rapid) assessment may be indicated to define the full extent of the trachoma endemic areas, we know there are Indigenous communities with rates of active trachoma as high as any in the world and we know that many of these communities are not receiving any treatment.

We know more than enough about trachoma to act now.

MYTH # 3

"Trachoma is not a problem."

The World Health Organization has set a community prevalence of greater than 5% of active trachoma in children aged 1 to 9 years as the threshold for trachoma as a public health problem. For trichiasis the threshold is more than 1 case per thousand people.

Three quarters of the reported Indigenous communities in outback Australia exceed this threshold.

Trachoma disappeared from mainstream Australia 100 years ago with improved living conditions and in the absence of specific control measures. However, without intervention, trachoma will keep Indigenous communities in a cycle of poverty as the disease is passed on from one generation to the next.

MYTH # 4

"Trachoma control is not possible in Indigenous communities because people move around."

The widespread travelling of Indigenous people does present a logistic problem for trachoma control.

However, most (if not all) transmission occurs within the intimate setting of the family and visitors and migrants only provide a secondary source of infection.

Control of trachoma is everyone's business, involving clinics, schools and communities.

The synchronised regional co-ordination of trachoma screening in schools and clinics will mean few people are omitted from receiving treatment in one community or another.

MYTH # 5

"Trachoma and chlamydia are the same."

The bacterial strain of Chlamydia trachomatis which causes trachoma differs from the genital strain.

Serovars usually responsible for trachoma are A, B, Ba and C. Serovars D-K are the causative agents of genital Chlamydia infection.

Genital serovars are occasionally the cause of eye disease in infants, adolescents, and adults in trachoma endemic areas. Infected secretions are spread from the genitals to eyes in the same person, or during birth from mother to baby.

It is extraordinarily rare for trachoma serovars to cause genital tract chlamydia.

The chlamydia STI is caused by closely sharing infected genital secretions - leading to salpingitis and infertility if untreated.

Trachoma is caused by closely sharing infected eye secretions - leading to scarring and blindness if untreated.

MYTH # 6

"Trachoma does not blind Indigenous Australians."

This is not true. Trachoma causes 9% of blindness in Indigenous Australian adults.

Rates of scarring, trichiasis, corneal opacity and blindness in Australia are little changed from what they were there 30 years ago and are comparable to the worst affected communities in Africa.

The F component of SAFE

Facial cleanliness is the *critical final common pathway* through which a variety of environmental factors affect the risk of trachoma transmission

MYTH # 7

"Its normal for kids to have dirty faces."

Children do get dirty easily when they play. But it is not normal for a child to have visible nasal and ocular secretions on their faces each day.

The presence of dirty faces is the final common pathway in the interaction of all environmental risk factors for trachoma, facilitating frequent exchange of infected ocular or nasal secretions from one child's face to another child's eyes.

Increasing facial cleanliness has been shown to be possible even in environments where water is scarce.

Promoting the benefits of clean faces, handwashing and good hygiene practices in clinics, schools and communities will help eliminate trachoma and support all health and well-being programs.

MYTH # 8

"Old people usually have sore eyes and poor vision."

It is not normal for older people to have sore eyes and poor vision.

Clinics may have requests for eye ointment or epilation (removal of eyelashes) if the eyelashes touch the cornea. This is not recommended as lashes will re-grow and broken lashes will act as a bristle and damage the cornea further.

Never give soothing eye drops without checking for trichiasis.

Trichiasis surgery can reduce the risk of blindness and improve quality of life.

Where trachoma is endemic, adults over 40 should be screened every year for trichiasis as part of the healthy adult check.

MYTH # 9

"Trachoma will not be eliminated until Aboriginal housing is improved."

It is true that the gross inadequacy of Aboriginal housing and that poor health hardware, such as plumbing and working taps is an important risk factor for a number of diseases including trachoma.

However, it has been shown that the control of trachoma with the SAFE Strategy does not need to wait until Aboriginal housing is improved.

The key environmental intervention for trachoma control is removing the barriers to face washing and good hygiene practices such as school wash troughs and maintenance of home washing facilities.

MYTH # 10

"Trachoma control is made harder because the workforce changes frequently."

The workforce in remote health services is known to be transient, therefore ongoing development and capacity building for clinical staff is required at a number of levels to best equip practitioners in the delivery of Trachoma Control Programs across Australia.

Supports are now available:

- The Remote Area Health Corps (RAHC) attracts urban-based health professionals to provide short-term staffing placements for remote Indigenous communities to contribute to "closing the gap" in Indigenous health.
<http://www.rahc.com.au/>

- RAHC also provides an extensive suite of online clinical training modules for remote health workers. These are freely available to remote health practitioners across Australia. The newly developed trachoma module provides orientation and step-by-step learning materials to increase knowledge, skill and practice in the workforce.
<http://www.rahc.com.au/training/>

- The Northern Territory Centre for Disease Control Trachoma Program team includes a Trachoma Educator who travels throughout the Northern Territory providing in-service training and support to staff in all organisations involved in trachoma control.
ph (08) 8951 9514
http://www.health.nt.gov.au/Centre_for_Disease_Control/index.aspx

- The Trachoma Story Kit is a comprehensive suite of resources, information and material for clinics, schools and communities for use in Trachoma Control Programs across Australia.
http://www.iehu.unimelb.edu.au/trachoma_resources/introduction
Note: Centre for Disease Control NT provides kits free in trachoma endemic areas of the Northern Territory.
Contact ph (08) 8951 9514

- The Centre for Eye Research (CERA) Trachoma Self Grading CD-ROM is an interactive self directed learning tool with detailed lessons and photographs for trachoma training and grading.

The CD-ROM can be purchased from CERA
<http://www.cera.org.au/our-work/resources/software-cds-dvds>
or is freely available for interactive learning
<http://www.iehu1.unimelb.edu.au/trachoma/>

Trachoma is entirely preventable

Culturally specific health promotion resource for trachoma elimination programs in Australia

The Trachoma Story Kit was developed as a set of three Kits one each for Clinics, Schools and Communities with the key message of "Clean Faces Strong Eyes"

The Kits were developed by the Indigenous Eye Health Unit at the University of Melbourne in close consultation with the Ngumpin Reference Group of Katherine West Health Board, and the Northern Territory Centre for Disease Control.

The Ngumpin Reference Group is a consultative group of Indigenous board members and Aboriginal Health Workers, who provided input and guidance over a 12 month period ensuring the Trachoma Story Kits were culturally appropriate and without an institutional or non-Aboriginal perspective.

All materials are in easy to read, user friendly language incorporating clinical know how, cultural knowledge and practice, with engaging realistic images of contemporary Indigenous communities.

Katherine West Health Board
<http://www.kwhb.com.au/>

Trachoma can be eliminated in Indigenous communities using the SAFE Strategy, however for its success trachoma prevention must become everyone's business.

The three Trachoma Story Kits will engage, educate and equip teachers, clinicians and community workers to teach children, patients and the wider community about trachoma, its treatment and prevention.



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Available from Indigenous Eye Health Unit, Melbourne School of Population Health, The University of Melbourne (03) 9035 8241

The Trachoma Story Kit for Clinics brings together the latest clinical guidelines and trachoma grading tools along with newly developed flipcharts, posters, teacher's books and other engaging resources to support clinical staff in trachoma screening, treatment and prevention.

The Trachoma Story Kit for Schools provides six ready made lesson plans and activities, to engage and educate primary school children about the role of face washing and good personal hygiene practices. Lesson plans address the NT and WA school syllabus and are being adapted for SA schools.

The posters, flipcharts, children's DVD and workbooks, will support staff in schools, pre-schools and childcare centres talk to children about trachoma and how to prevent it.

The Trachoma Story Kit for Communities is for anyone who lives and/or works in a remote Indigenous community and wants to know more about trachoma and how to prevent it.

The Kit will help people understand the essentials including; 'What is trachoma?', 'Where is it found?' and 'What can be done by individuals and communities to prevent trachoma?'

To be more user friendly all Kits include a DVD with files of the teacher and student workbooks, the Trachoma Resource Book and all three posters and flipcharts for download. This enables adaptability to new teaching technologies such as Smartboards.

http://www.iehu.unimelb.edu.au/media/video_podcasts

Trachoma Story Kits can be ordered through
www.iehu.unimelb.edu.au/trachoma_resources/order_form

Some components are freely available to download here
http://iehu.unimelb.edu.au/trachoma_resources/free_downloads