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LETTERS

TRACHOMA CONTROL

Don't let misinformation derail the trachoma elimination programme

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Chisholm and colleagues' paper is important to policy makers,[1] so serious errors in the trachoma analysis require correction.[2]

Firstly, "mass treatment with azithromycin" for trachoma was defined as azithromycin treatment for all children aged 1-10 years,[3] whereas the World Health Organization recommends treatment of all residents.

Secondly, data from a 1998-9 western Nepal trial were extrapolated to estimate effectiveness of mass treatment throughout sub-Saharan Africa and South East Asia.

Thirdly, the model's coverage level parameter "does not affect the reduction in the prevalence of active trachoma"[3]; we doubt that this is true.

Fourthly, disability weights were assigned only for the outcomes visual impairment and blindness.[3] Trichiasis has considerable physical, social, and economic effects from its onset, not just after low vision ensues. Furthermore, active trachoma was denied a disability weight, and the ancillary savings in disability adjusted life years (DALYs) of mass azithromycin treatment (which may include reduced all cause mortality in children[4]) were ignored.

Fifthly, WHO and partners aim to eliminate trachoma as a public health problem by 2020. An elimination programme derives positive externalities (in economic terms) from protection of future generations. It is a mistake to assess infectious diseases in the same way that cataract is assessed.

Lastly, costs were assigned for azithromycin purchase using a theoretical price.[2] Azithromycin for trachoma control is donated by the manufacturer.

On the basis of analyses that are flawed on both sides of the cost effectiveness equation, Chisholm and colleagues concluded that saving a DALY with mass azithromycin treatment in trachoma endemic areas of sub-Saharan Africa or South East Asia costs more than the per capita gross domestic product of each region. International commitment to trachoma control has never been stronger,[5] and it would be tragic for poor communities affected by trachoma if programme momentum was lost through misinformation.

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This is a shortened version of a rapid response, which appears in full at: www.bmj.com/content/344/bmj.e586/rr/575171.

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2 Baltussen R, Smith A. Cost effectiveness of strategies to combat vision and hearing loss in sub-Saharan Africa and South East Asia: mathematical modelling study. *BMJ* 2012;344:e615. (2 March.)
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4 Porco TC, Gebre T, Ayele B, House J, Keenan J, Zhou Z, et al. Effect of mass distribution of azithromycin for trachoma control on overall mortality in Ethiopian children: a randomized trial. *JAMA* 2009;302:962-8.
5 International Coalition for Trachoma Control. The end in sight: 2020 INsight. 2011. www.trachomacoalition.org/category/resource-type/documents.

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