

Australian Trachoma Surveillance Report 2024

The Kirby Institute, UNSW Sydney

WHO Collaborating Centre for Neglected Tropical Diseases*

Prepared by the National Trachoma Surveillance and Reporting Unit at the Kirby Institute, UNSW Sydney on behalf of Australian organisations involved in trachoma control activities, under a funding agreement with the Australian Government.

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Preface

This report was prepared by the National Trachoma Surveillance and Reporting Unit (NTSRU) in collaboration with the National Trachoma Surveillance and Control Reference Group and jurisdictional health departments funded to undertake trachoma control activities by the Australian Government Department of Health, Disability and Ageing, which also funds the NTSRU.

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Previous reports are available online at <https://kirby.unsw.edu.au/report-type/australian-trachoma-surveillance-reports>

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Technical terms and definitions

Active trachoma

Defined according to WHO simplified grading criteria as trachomatous inflammation – follicular and/or trachomatous inflammation – intense.

At-risk communities

A community is classified as ‘at risk’ of trachoma by state/territory health departments if at least once within the past five years, prevalence of trachomatous inflammation – follicular and/or trachomatous inflammation – intense is 5% or more in children aged 5–9 years screened.

Clean face

Absence of nasal and ocular discharge on the face.

Community-wide treatment

The antibiotic treatment of all people in the community who weigh more than 3 kg living in houses with children under 15 years of age.

Contacts

Anyone who is living and sleeping in the same house as a child with trachoma. If the child lives or sleeps in multiple households, then all members of each household are regarded as contacts.

Elimination of trachoma as a public health problem

Defined according to the World Health Organization (WHO) as: a prevalence of trachomatous trichiasis “unknown to the health system” of <0.2% in ≥15-year-olds in each formerly endemic district, and a prevalence of trachomatous inflammation—follicular in children aged 1–9 years of <5% maintained for at least two years in the absence of mass drug administration for disease control in each formerly endemic district.ⁱ

Hyperendemic trachoma

Prevalence of observed trachoma of 20% or more in children aged 5–9 years.

Mass drug administration (MDA)

Distribution of medicines to the entire population of an administrative area (for instance, state or region), irrespective of the diagnosis or presence of symptoms of a disease.

Prevalence of trachoma

Defined as:

ⁱ Refer to Methodology section for how Australia’s targets and processes differ from WHO guidelines.

Observed prevalence: The proportion of cases of trichomatous inflammation – follicular and/or trichomatous inflammation – intense identified in children aged 5–9 years in communities currently classified as at risk and screened during the current calendar year.

Estimated prevalence: The proportion of cases of trichomatous inflammation – follicular and trichomatous inflammation – intense identified in children aged 5–9 in all communities currently classified as at risk, according to the most recent screening conducted.

Overall prevalence: The proportion of cases of trachoma identified in children aged 5–9 years in all communities ever classified as at risk, according to the most recent screening recorded. This is the measure used for assessing Australia's progress against WHO targets.

Screening coverage

The proportion of Aboriginal and Torres Strait Islander children aged 5–9 years residing in the community who were screened for trachoma.

Trichomatous inflammation – follicular (TF)

The presence of 5 or more follicles in the central part of the upper tarsal conjunctiva, each at least 0.5 mm in diameter, in the central part of the upper tarsal conjunctiva

Trichomatous inflammation – intense (TI)

Pronounced inflammatory thickening of the upper tarsal conjunctiva that obscures more than half of the normal deep tarsal vessels.

Trichomatous trichiasis (TT)

At least one eyelash from the upper eyelid touches the eyeball, or evidence of recent epilation of in-turned eyelashes from the upper eyelid.

Treatment coverage

The proportion of Aboriginal and Torres Strait Islander people in a community who weigh more than 3 kg and who were treated for trachoma within two weeks of screening relative to the number of people identified as requiring treatment under public health guidelines.

Abbreviations

APY	Anangu Pitjantjatjara Yankunytjatjara
ACCHS	Aboriginal Community Controlled Health Service
CDNA	Communicable Diseases Network Australia
IEHU	Indigenous Eye Health Unit
NSW	New South Wales
NT	Northern Territory
NTSCRG	National Trachoma Surveillance and Control Reference Group
NTSRU	National Trachoma Surveillance and Reporting Unit
PCR	Polymerase chain reaction
Qld	Queensland
SA	South Australia
SAFE	Surgery, Antibiotics, Facial cleanliness, and Environmental improvement
TF	Trachomatous inflammation – follicular
TI	Trachomatous inflammation – intense
TT	Trachomatous trichiasis
WA	Western Australia
WACHS	WA Country Health Service
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

Executive summary

Trachoma is the world's leading infectious cause of preventable blindness and is linked to poor living conditions. Infection with ocular strains of the bacterium *Chlamydia trachomatis* leads to inflammation of the conjunctiva under the upper eyelid — most commonly trachomatous inflammation – follicular (TF) and/or trachomatous inflammation – intense (TI) — known as active trachoma. Repeated infections can lead to scarring of the upper eyelid, causing the eyelashes to turn inward (trachomatous trichiasis or TT) to scratch the cornea, eventually resulting in vision loss or blindness.^{1, 2} The World Health Organization (WHO) through the Alliance for the Global Elimination of Trachoma advocates the SAFE strategy for trachoma control.³ The SAFE acronym highlights the key components of the strategy, which are *Surgery* for TT, *Antibiotic* treatment for *C. trachomatis* infection, and the promotion of *Facial cleanliness* and *Environmental* improvement to reduce transmission and prevent reinfection.

Australia remains the only high-income country with endemic trachoma, primarily found in remote Indigenous communities within northern, central, and western regions. WHO criteria for elimination of trachoma as a public health problem include maintaining for at least two years prevalence of TF under 5% in children and TT 'previously unknown to the health system' under 0.2% in the population aged 15 years and older.⁴ Australia first reached these targets in each formerly endemic jurisdiction (state/territory) in 2022. The 2024 surveillance data show that Australia remains under the thresholds for elimination of trachoma as a public health problem and is therefore eligible to apply to WHO for global recognition of this status from 2025. A dossier documenting these achievements is currently in preparation.

The Australian Government implemented the National Trachoma Management Program in 2006. The Communicable Diseases Network of Australia promulgated guidelines (CDNA Guidelines) for trachoma control (2006, updated 2014) and the National Trachoma Surveillance and Control Reference Group (NTSCRG) was formed in 2011, to provide technical guidance and an integrated approach to the program. Based on previous epidemiological surveys, the National Trachoma Management Program initially focussed on remote and very remote Indigenous communities in the Northern Territory (NT), South Australia (SA), and Western Australia (WA).^{5, 6} New South Wales (NSW) and Queensland (Qld), the two other jurisdictions with historical evidence of trachoma endemicity, undertook mapping exercises to determine whether trachoma still existed as a public health problem (NSW from 2013–2015 and Qld from 2012–2021). Following data received from these mapping exercises, the NTSCRG endorsed NSW and Qld as not at risk of endemic trachoma in 2017 and 2022, respectively.

With the receipt of 2024 surveillance data, the NTSCRG agreed in June 2025 to also endorse SA's re-classification as free of endemic trachoma. No cases of active trachoma have been reported in SA since 2022, whilst total cumulative screened prevalence of previously unidentified TT cases was 0.1% during this period. SA joins NSW and Qld in no longer requiring active trachoma screening as per CDNA Guidelines. In the two other jurisdictions, WA and the NT, surveillance and treatment activities will continue in remaining at-risk communities during the peri-elimination period.

As Australia moves towards recognition of elimination of trachoma as a public health problem, further action to address environmental risk-factors is needed to sustain achievements, particularly in housing quality to support health outcomes in remote communities. Ongoing surveillance is required to track and

respond to any resurgence of trachoma, and accessible TT diagnosis and surgery pathways must remain in place to address long-term disease impacts. Aboriginal and Torres Strait Islander leadership must underpin future strategies developed to ensure local ownership and accountability to communities.

Summary of findings

Trachoma program coverage

In 2024, three jurisdictions (NT, SA, and WA) identified communities across 11 sub-regions as at risk of trachoma and requiring screening as per CDNA Guidelines (Figure 1.1).

Within these jurisdictions, 35 at-risk communities were identified in the NT, 11 in SA, and 26 in WA.

Jurisdictional trachoma control programs in NT and SA undertook additional screening as part of evidence confirmation for WHO dossier validation. This additional screening included 13 communities previously removed from the at-risk register with geographic and cultural linkages to current at-risk communities, plus five at-risk communities not due for screening in 2024 under CDNA Guidelines. For the purposes of simplicity, results from these 18 communities that would not normally require screening in 2024 are counted as at-risk communities and included in 2024 results.

This gives a sum of 90 remote Indigenous communities designated as at risk of trachoma and requiring screening in 2024.

WA reported seven other communities as at risk of trachoma yet not due for screening in 2024 under CDNA Guidelines. This brings to 97 the total number of all communities designated as at risk of trachoma in 2024 (Table 1.1).

The number of communities at risk of trachoma in Australia has declined across all jurisdictions, even when including the additional communities screened in 2024. Between 2010 and 2024, the number of at-risk communities fell by 43% in the NT (84 in 2010 to 48 in 2024), by 78% in SA (72 in 2010 to 16 in 2024), and by 62% in WA (86 in 2010 to 33 in 2024) (Figure 1.2).

Screening coverage

Screening is conducted during a dedicated visit by jurisdictional control programs or primary health services.

Jurisdictional trachoma control programs screened 86 of the 90 communities designated for screening in 2024 (96%) (Table 1.1).

Within these communities, 1,885 of an estimated 2,119 resident children aged 5–9 years were screened for trachoma in 2024 (89%) (Table 1.2). This is similar to the national screening coverage for at-risk communities in 2023 (91%).

Screening coverage at the jurisdictional level was fairly uniform at 87% in the NT, 91% in SA, and 92% in WA in 2024 (Table 1.2).

At the regional (sub-jurisdictional) level, screening coverage ranged from 86% in Anangu Pitjantjatjara Yankunytjatjara (APY) Lands (SA) and Kimberley (WA) to 99% in Eyre and Far Western region (SA) (Tables 2.2, 4.2, 5.2) ⁱⁱ.

ⁱⁱ In regions where at least 20 children were screened.

Facial cleanliness

Jurisdictional trachoma control programs also examined a total of 1,984 children aged 5–9 years for facial cleanliness during trachoma screening (Table 1.2).

The national proportion of clean faces in children screened in 2024 was 79%, with clean face proportions 76% in the NT, 89% in SA, and 76% in WA (Table 1.2).

Clean face proportion ranged from 44% in the Pilbara (WA) to 99% in SA's Far North (Tables 2.2, 4.2, 5.2)ⁱⁱⁱ.

Trachoma prevalence

The observed prevalence of active trachoma is defined as the proportion of TF or TI (classified according to WHO simplified grading criteria) amongst children screened in 2024.

Among the 86 communities screened in 2024, 25 communities (29%) reported at least one case of active trachoma. There were 18 communities (21%) that had an observed prevalence of active trachoma at or above 5% in children aged 5–9 years (Table 1.3).

The proportion of communities with hyperendemic trachoma (observed prevalence at or above 20% active trachoma) was 6% (5/86) of all communities screened in 2024, similar to the rate of 7% in 2023 (Table 1.3).

The varying and often small size of communities screened should be considered in interpretations of observed trachoma prevalence.

The overall prevalence of trachoma in 5–9-year-olds includes the last recorded active trachoma prevalence in all communities ever considered at risk of trachoma, and is the measure used to assess progress towards WHO benchmarks.

The overall prevalence of trachoma in children aged 5–9 years was 2.1% in the NT, 0% in SA, and 1.3% in WA (Table 1.2).

Overall trachoma prevalence among all current and former at-risk communities nationally decreased slightly from 1.8% in 2023 to 1.5% in 2024 (Figure 1.5c, Table 1.2).

In 2024, four out of the 11 sub-jurisdictional regions had an overall prevalence of trachoma of 0%: APY Lands (SA), Eyre and Western (SA), Far North (SA), and Midwest (WA). In the remaining regions, the overall prevalence of trachoma ranged from 0.4% in the Darwin Rural region (NT) to 5.0% in the Alice Springs Remote region (NT) (Figures 1.1, 2.1, 4.1, 5.1).

Antibiotic distribution and coverage

Antibiotic distribution took place in all 25 communities where treatment was required based on the CDNA Guidelines (Table 1.4).

Jurisdictional trachoma programs distributed a total of 1674 doses of azithromycin in 2024. As in previous years, the majority of antibiotic distribution took place in the NT (Figure 1.9, Table 1.5).

Treatment coverage for active cases detected in screening activities was 96% with 69 out of 72 cases receiving azithromycin (Table 1.5), slightly under the coverage of 99% for active cases in 2023.

ⁱⁱⁱ In regions where at least 20 children were screened.

Coverage for household and community contacts requiring treatment under CDNA Guidelines was 53% (Table 1.5), notably lower than 81% in 2023.

Trachomatous Trichiasis (TT)

Screening for TT was undertaken by various methods including by trachoma control teams during trachoma screening activities, by regional optometrist services, and opportunistic screening during the Aboriginal and Torres Strait Islander Peoples Health Assessment (also called the 715 health check), which is covered by Medicare.

A total of 18,931 people aged 15 years and over in 165 communities or services were reported as screened for TT in 2024 (Table 1.6).

Amongst people screened in 2024, 9 (0.05%) were found to have TT. All cases were identified in those aged 40 years or older (Table 1.6).

Surgery for TT in the past 12 months was reported to have been undertaken for six adults (Table 1.6).

Facial cleanliness and environmental improvement activities

Narrative information on facial cleanliness and environmental health improvement activities is provided by jurisdictional health departments, community-controlled organisations and non-government partners.

Activities to promote facial cleanliness also incorporate health promotion to enhance general hygiene-related behaviours in children. There were 210 related activities undertaken in at-risk and previously at-risk communities in the NT, Qld, SA, and WA in 2024. (Tables 2.7, 3.1, 4.6, 5.7).

Environmental health improvement programs are jurisdictionally specific, although typically involve some combination of the following: routine home assessments and maintenance; procurement and distribution of home health hardware and related supplies; workforce development and policy advice.

Background

Trachoma is the world's leading infectious cause of preventable blindness.⁷ It is characterised by two linked processes. Infection with serovars A-C of the bacterium *Chlamydia trachomatis* leads to inflammation of the conjunctiva known as active trachoma, characterised by the presence of multiple follicles or lumps (TF) on the upper tarsal conjunctiva (upper inner eyelid), or pronounced thickening obscuring more than half the normal deep tarsal vessels (TI). Repeated infection, particularly during childhood, drives chronic scarring and the second, non-communicable stage. Scarring can cause eyelashes to rotate inward to scratch the outer surface of the cornea. The resulting damage to the cornea by TT is the main pathway by which trachoma leads to vision loss and blindness.^{1, 8-10} Scarring is irreversible but if early signs of in-turned eyelashes are found, surgery to the eyelid is usually effective in preventing further damage to the cornea.¹¹ As of July 2025, trachoma was considered to be endemic in at least part of 32 countries, with an estimated 1.2 million persons experiencing the most severe forms of vision impairment related to the disease.⁷ Australia has remained the only high-income country where trachoma is considered a public health problem.

Transmission of ocular *C. trachomatis* occurs through close facial contact, hand-to-eye contact, via contamination of personal items (such as towels, clothing, and bedding) and possibly by flies.^{12, 13} Trachoma generally occurs in dry, dusty environments and is strongly associated with poor living conditions. Crowding in households, limited water supply for bathing and general hygiene, and poor waste disposal systems have all been associated with trachoma prevalence.⁶ Children have more frequent and longer-lasting episodes of infection than adults and are generally believed to be the main community reservoirs of infection.¹⁴

The World Health Organisation has set technical benchmarks for the elimination of trachoma as a public health problem, that is, the reduction in trachoma disease prevalence to such a level that it no longer contributes significantly to morbidity at the population level.^{4, 15} This requires: (i) a prevalence of TT 'unknown to the health system' of less than 0.2% in people 15 years or older in each formerly endemic district; (ii) a prevalence of TF of less than 5% in children aged 1–9 years maintained for at least two years in each formerly endemic district; and (iii) written evidence that the health system can identify and manage incident cases of TT, with evidence of appropriate financial resources to implement those strategies. Formal validation of elimination as a public health problem is sought from WHO through the submission of a dossier.¹⁶

Trachoma control in Australia

The Australian Government established the National Trachoma Management Program in 2006. This provides a federally funded, nationally consistent approach to trachoma control in accordance with Australia's global commitments through:

The development of Australia's first national guidelines for the public health management of trachoma (updated in 2014), under the guidance of CDNA and in accordance with the SAFE strategy.¹⁷

The establishment of National Trachoma Surveillance and Reporting Unit (NTSRU) to provide a national mechanism for monitoring trachoma prevalence and related control activities.

The formation (in 2011) of the NTSCRG as the entity responsible for guiding Australia's effort to eliminate trachoma as a public health problem. The NTSCRG comprises federal and state/territory jurisdictional government health, housing and environmental health representatives, epidemiological and public health experts, and key non-governmental partners with expertise in Aboriginal and Torres Strait Islander health across all components of the SAFE strategy, including representatives of the Aboriginal Community Controlled Health (ACCH) sector.

Most recently, the Australian Government has invested \$23.6 million from 2021-22 to 2024-25 towards eliminating trachoma as a public health problem through the continuation and development of trachoma surveillance, health promotion, and environmental improvement initiatives in the NT, Qld, SA, and WA.

The National Trachoma Surveillance and Reporting Unit (NTSRU)

The NTSRU is responsible for data collection, analysis, and annual reporting of surveillance and SAFE activities in collaboration with relevant jurisdictions and health services. The Kirby Institute, UNSW Sydney has managed the NTSRU since 2010,¹⁸⁻³⁰ with the Centre for Eye Research Australia³¹⁻³³ and the Centre for Molecular, Environmental, Genetic and Analytic Epidemiology at The University of Melbourne³⁴ responsible during 2006–2010.

Methodology

The surveillance and management of trachoma are guided by the CDNA 2014 *National Guidelines for the Public Health Management of Trachoma in Australia* (CDNA Guidelines)¹⁷. CDNA Guidelines were developed in the context of the WHO SAFE strategy and address control strategies as well as data collection, reporting, and analysis.

The primary source of the data presented in this report is programmatic reporting from Australian jurisdictions (states/territories) which undertook trachoma control initiatives in 2024. Data are collected at the community level, using forms developed by the NTSRU based on CDNA Guidelines. Completed forms are forwarded each calendar year by jurisdictional coordinators to the NTSRU for analysis. Information provided includes:

Number of Indigenous children aged 5–9 years screened for active trachoma and the number with active trachoma.

Number of episodes of treatment for active trachoma, household contacts, and other community members, by age group.

Number of Indigenous people aged 15 years and over screened for TT, number with TT ‘unknown to the health system’, and the number who had surgery for TT.

Number of Indigenous children aged 5–9 years screened for clean faces and the number with clean faces.

Community-level implementation of health promotion activities.

Narrative information about environmental health improvement activities is also provided at this time.

WHO simplified trachoma grading criteria² form the basis of identification of cases of active trachoma in Australia. Trachoma is defined by the NT, SA, and WA as the presence of TF and/or TI. In Qld, trachoma screening is based upon a detailed clinical assessment performed by an experienced ophthalmologist beyond that required by the WHO simplified grading system, including examination for Herbert’s pits and corneal pannus that are considered highly specific for trachoma, as well as laboratory confirmation of *C. trachomatis* infection biomarkers.

Trachoma control programs in Australia undertake trachoma grader training based on the Tropical Data training system, an international consortium that supports the conduct of trachoma prevalence surveys in accordance with World Health Organization recommendations.³⁵

WHO criteria relate to trachoma prevalence in children aged 1–9 years. However, the target group for screening activities in Australia since 2006 has been children aged 5–9 years. This narrower age group was chosen because of accessibility through schools, greater acceptability of eye examination and a presumption that prevalence in 5–9-year-olds would be similar to the prevalence in 1–4-year-olds. In 2018, in anticipation of WHO dossier preparation, a concerted effort was made to achieve high screening coverage in the 1–4-year age group, to check this assumption. The results showed that there was no evidence of higher prevalence in the younger age group and this finding was consistent between jurisdictions. Furthermore, the finding of no significant difference in prevalence in the two age groups was observed both in communities that achieved high levels of screening in 1–4-year-olds, and those that did

not.²⁷ Based on these results, screening has continued to focus on the 5–9-year age group, although children aged 1–4 years and 10–14 years may still be screened opportunistically.

WHO guidelines recommend that trachoma is treated with a single dose of the antibiotic azithromycin. When prevalence exceeds 5% in children aged 1–9 years, WHO guidelines recommend mass drug administration to the entire region or district. CDNA Guidelines differ from WHO recommendations in several respects. Australia uses the community trachoma prevalence of the 5–9-year age group as a basis for treatment, rather than the 1–9-year age group. In communities with prevalence less than 5%, treatment is provided to the active case/s (children with TF and/or TI) and their household only. If prevalence is greater than or equal to 5%, treatment may be offered to all households in the community with at least one child aged 15 years or under – known as community-wide treatment – in the absence of case clustering (cases concentrated in distinct households and where health staff can clearly identify all contacts). Mass drug administration of the whole population across entire regions or jurisdictions is not undertaken in Australia.

Data analysis

A community is defined as a geographic location where people reside and there is at least one school. Data are aggregated to the regional level to protect community confidentiality. Regions are aligned with state/territory health department public health administration zones.

Trachoma screening coverage is the proportion of resident children aged 5–9 years in identified at-risk communities who were screened in the calendar year. Since 2012, estimates of resident population numbers in each community are derived by each jurisdiction using enrolment lists from schools and health clinics, supplemented by local advice on movement into and out of communities. For 2007 to 2011, estimates were based on projections from the 2006 Australian census using the Australian Bureau of Statistics standard estimates of annual population increase (1.6%, 1.8%, and 2.1% in the NT, WA, and SA respectively).

Treatment coverage is defined as the proportion of active cases plus household/community contacts requiring treatment according to CDNA Guidelines and who received azithromycin within two weeks of screening.¹⁷

Data from 2006 are excluded from the assessments of time trends as collection methods in this first year of the control program differed substantially from those subsequently adopted.

Calculations for trachoma prevalence

Australia's CDNA guidelines, first released in 2006, called for annual examination of children in communities designated as at risk and used the results of these examinations to calculate prevalence. The 2014 revision of the CDNA Guidelines provided the option not to screen all at-risk communities every year, with jurisdictions instead able to allocate resources for antibiotic distribution and health promotion activities. Communities with less than 5% prevalence for 5 years or more may be reclassified by jurisdictional health departments as no longer at risk of trachoma and removed from screening requirements. Consequently, three methods of calculating trachoma prevalence are presented in this report.

1. The *observed prevalence* of trachoma is calculated using only the data from screening activities undertaken during the reporting year.
2. The *estimated prevalence* of trachoma is calculated by combining observed prevalence with the most recent prevalence data carried forward from communities designated at risk in the reporting year and not screened, following a method endorsed by the NTSCRG. This method may result in an over-estimation of prevalence, particularly for communities not screened but which received community-wide treatment with antibiotics during the previous year.
3. The *overall prevalence* of trachoma is calculated by combining prevalence from at-risk communities screened during the reporting year, the most recent prevalence carried forward from at-risk communities that were not screened in the reporting year (estimated prevalence), and the most recent prevalence carried forward from all communities previously classified as at risk but judged by jurisdictions to no longer have endemic trachoma and therefore removed from the at-risk register. National overall prevalence calculations do not include data from NSW and Qld as these jurisdictions undertook targeted mapping exercises rather than a sustained screening program. Overall prevalence is the measure used to assess Australia's progress towards elimination of trachoma as a public health problem.

During the evolution of the National Trachoma Management Program, two jurisdictions have amalgamated data from communities with very small populations and high inter-community mobility to ensure confidentiality and enhance programmatic decision-making. In WA, 10 communities in the Goldfields region have been reported as a single unit since 2011 and four communities in the Pilbara region have been reported together from 2016. The nine communities of SA's APY Lands have been reported as a single unit from 2014. Community-specific data for communities subsequently amalgamated were used (or carried forward) until the year of amalgamation. These changes need to be considered in the interpretation of data patterns for SA and WA.

Trachomatous Trichiasis (TT)

TT is reported as the crude proportion of cases 'unknown to the health system' identified in the calendar year, in line with WHO criteria.³⁶ This excludes cases detected in previous years, people on surgical waiting lists or who have refused surgery, and TT in individuals with post-surgical recurrence.

Jurisdictional screening programs

New South Wales

There were no regions designated at risk of trachoma in NSW in 2024. Mapping was undertaken by NSW Health between 2013 to 2015 in north-western and far-western regions that had historical evidence of trachoma endemicity or share borders with at-risk regions in NT and SA. The NSW mapping did not identify any regions with endemic trachoma.

Northern Territory

In 2024, four regions in the NT identified communities at risk of trachoma. Since 2009, the NT's Trachoma Control Program has been located within the Centre for Disease Control in the NT Department of Health (NT Health). Activities are delivered in partnership with the Aboriginal Medical Services Alliance Northern

Territory, the peak body for NT's Aboriginal Community Controlled Health Services (ACCHS), and its member organisations. In Alice Springs Remote, Barkly, Darwin Rural, and (formerly) East Arnhem regions, NT Health Trachoma Control Program staff coordinate annual trachoma screening, antibiotic treatment, and facial cleanliness health promotion activities. These activities in the Katherine region are undertaken by Katherine West Health Board Aboriginal Corporation and (formerly) Sunrise Health Service Aboriginal Corporation under service agreements with NT Health.

In 2024, screening for TT across the NT was undertaken opportunistically, primarily by clinicians during the annual health assessment for Aboriginal and Torres Strait Islander people (also called the 715 health check) or by optometrists and ophthalmologists based with regional eye health services.

Queensland

There were no regions designated at risk of trachoma in Qld in 2024 and no communities screened. Trichiasis screening and facial cleanliness health promotion activities to prevent recrudescence were undertaken in one community in North-West Qld.

Enhanced trachoma mapping was undertaken in Qld from 2016 to 2021 due to the disparity between prevalence of TF which would indicate continuing endemicity and the absence of end-stage trachomatous disease. In November 2019, cumulative data from the Torres Strait Islands that showed no ocular C. trachomatis detection by polymerase chain reaction (PCR) from 2016–2019, evidence of other pathogens that can produce follicular trachoma, and confirmation of no presentations of trachoma-related corneal opacity, trachoma-related trichiasis or resultant visual impairment within the previous 30 years 37, 38 were presented to the NTSCRG, which agreed that these communities should no longer be considered as at risk of endemic trachoma. Further data from the North-West region collected between 2019–2021 identified no or very low rates of ocular C. trachomatis detected by PCR, limited signs of chronic sequelae, as well as serological prevalence of antibodies to chlamydial infection (anti-Pgp3) consistent with limited exposure to infection in young children. These data were reviewed in 2022 by the NTSCRG, which also endorsed this region, and thus all of Qld, as not at risk of endemic trachoma.

South Australia

SA's Trachoma Elimination Program is implemented by the Eyre and Far North Local Health Network on behalf of the SA Government. The program is overseen by the SA Trachoma Elimination Strategy Committee, jointly chaired by the Aboriginal Health Council of South Australia and the Eyre and Far North Local Health Network.

In 2024 there were three regions in SA with communities considered as at risk of trachoma; the APY Lands situated in the Eyre and Far North Region is considered for the purpose of this report as its own region. Due to no evidence of active trachoma since 2013, the Yorke and Mid North region is not considered at risk of trachoma.

Routine screening for TT is undertaken by ACCHSs via the 715 health check. The Eye Health and Chronic Disease Specialist Support Program coordinated by the Aboriginal Health Council of South Australia also provides opportunistic screening by visiting optometrists and ophthalmologists twice yearly to remote Aboriginal communities.

Western Australia

Trachoma screening and management in WA are the responsibility of the WA Country Health Service (WACHS), in collaboration with Population Health Units in the four regions with communities identified as at risk of trachoma: Kimberley, Goldfields, Pilbara, and Midwest. The WA Trachoma Reference Group provides program oversight and has established operational principles which guide the program and provide consistency in practice across the four regions.

In collaboration with local primary healthcare providers, WACHS and Population Health Unit staff undertake screening activities in communities in each region over a four-week period in August and September. Facial cleanliness health promotion activities are conducted in conjunction with screening. WA Environmental Health Directorate representatives also attend during screening visits to carry out environmental health assessments.

The priority target group for TT screening in WA is Aboriginal and Torres Strait Islander persons aged 40 years and over. Jurisdictional programs identify communities at risk of TT based on current and historical trachoma prevalence data. Screening for TT by regional Population Health staff is integrated into other community and public health programs such as the annual influenza vaccination program. TT screening also takes place at Aboriginal Medical Services during the 715 adult health check and by the Visiting Optometrist Service.

Findings and interpretation

In 2022, overall trachoma prevalence fell below the 5% endemicity threshold in Indigenous children aged 5–9 years in each jurisdiction or state/territory (Australia's units for evaluating trachoma control). To seek formal validation by WHO that Australia has eliminated trachoma as a public health problem, Australia has needed to maintain levels of overall trachoma prevalence below 5% as well as demonstrate that the prevalence of previously undiagnosed TT remains below 0.2% in people aged 15 years and over for a further two years. As this report shows, 2024 surveillance data demonstrates that prevalences remain below these thresholds at the jurisdictional level. Based on these results, Australia is eligible to apply for validation of elimination as a public health problem from 2025.

Screening coverage

There were 72 remote Indigenous communities designated as at risk of trachoma and requiring screening in 2024. NT and SA undertook additional screening as part of evidence confirmation for final-year dossier validation surveillance. These jurisdictions screened 13 communities previously removed from the at-risk register with population linkages to current at-risk communities as well as five at-risk communities not due for screening in 2024 under CDNA Guidelines. All 90 communities are included in report calculations.

The proportion of communities that received screening in 2024 (86/90, 96%) was slightly higher than the previous year (67/74, 91%), largely due to an improvement in the NT. The remaining communities could not be screened for a variety of reasons including staff/resourcing pressures and community factors.

CDNA Guidelines have a target of 85% of children aged 5–9 years examined for trachoma in each community screened. Of the 86 communities screened in 2024, 76 (88%) achieved this target (data not shown). Children not screened have either refused, did not have caregiver/parent consent, or were not available on the day of screening.

Facial cleanliness

Facial cleanliness reduces the risk of sharing infected ocular and nasal secretions between children, thereby interrupting transmission of chlamydial infection.³⁹ From 2023 to 2024, the proportion of children with clean faces increased slightly in all three jurisdictions (NT: 74% to 76%; SA: 85% to 89%; WA: 70% to 76%). CDNA Guidelines have a target of 85% of children aged 5–9 years with clean faces at the time of screening. In 2024, 42% (36/86) of screened communities reached this target (data not shown).

Since 2007, there has been considerable variation in the proportion of children screened with clean faces in jurisdictions and regions. This may reflect the complexity of facilitating sustainable behavioural change and indicates the importance of reducing ongoing environmental barriers to facial cleanliness, through improved access to safe and functional washing facilities, prompt repair and systemic maintenance of housing hardware as well as reducing crowding in homes.

Trachoma prevalence

Between 2023 and 2024 the overall prevalence of trachoma in children aged 5–9 years has remained at 0% in SA, declined by 0.3 percentage points in WA (1.6% to 1.3%), and declined by 0.2 percentage points in the NT (2.3% to 2.1%). Overall trachoma prevalence in all current and formerly endemic jurisdictions remains

below the threshold of 5% defined for elimination as a public health problem. Within these jurisdictions, 10 out of 11 regions with at-risk communities also recorded overall prevalences below 5%.

At least one case of active trachoma was reported among children aged 5–9 years in 29% of communities screened in 2024, although it should be noted that numbers of communities are low (25/86). The proportion of screened communities reporting any trachoma has been declining since 2020, when trachoma was reported in 71% (67/94) of communities screened. A similar pattern has been seen in communities reporting endemic levels of trachoma ($\geq 5\%$), which has declined from 59% (55/94) of screened communities in 2020 to 21% (18/86) in 2024. However, a minor number of communities screened in 2024 (6% or 5/86) reported hyperendemic trachoma ($\geq 20\%$ prevalence). The small size of communities (an average of 24 children were examined per community in 2024) should be considered in interpretations of observed screened prevalence.

Antibiotic distribution and coverage

Antibiotic treatment with azithromycin was indicated under CDNA Guidelines¹⁷ for 3,104 people in 2024, with 1,674 doses distributed or 54% treatment coverage. Treatment coverage was generally higher in communities that only undertook case and contact treatment (90%), compared to community-wide treatment (51%, data not shown). Low levels of treatment coverage are likely due to a combination of factors, including reports of treatment fatigue after many years of community-wide distribution and population movements.

Trachomatous Trichiasis (TT)

A total of 18,931 people aged 15 years and older were reported to have been screened for TT in the NT, Qld, SA, and WA, with nine cases 'unknown to the health system' identified in 2024. The total proportion of TT in screened people aged 15 years and older was 0.05% and in those aged 40 years and older was 0.09%. By jurisdiction, the proportion of TT in screened persons was 0.03% in the NT, 0.3% in Qld, 0.3% in SA, and 0% in WA. A total of six people from two jurisdictions were reported to have had TT surgery in 2024.

WHO thresholds for elimination as a public health problem refer to TT at a population level. Due to the relatively small number of locations in which trachoma has remained a public health issue, population wide assessments of TT at the state/territory level have not been considered appropriate⁴⁰ Reporting TT as the crude proportion among population screened, with screening linked to current and former trachoma endemic regions, is likely to over-estimate the true population level prevalence of TT in Australian jurisdictions, as the broader Indigenous population does not have the same exposure risk. The continuing low overall rate of new TT cases indicates Australia has met this benchmark.

Health promotion activities

Jurisdictional trachoma control teams, ACCHSs, and other organisations continue to deliver a wide range of health promotion activities to support facial cleanliness and related hygiene behaviours (for further details see jurisdictional results). Health promotion activities target diverse groups in the community to improve uptake, including children, young people, parents/caregivers, other community members, and local service

providers. Knowledge and skills building activities are delivered via interactive school programs, teacher and community health worker training, social/mass media campaigns, and at local community events. Programs incorporate the distribution of hygiene resources (e.g. soap, towels) and home cleaning supplies to translate knowledge into action.

Health promotion messages and materials are culturally tailored and developed in partnership with targeted communities. Facial cleanliness messages have been integrated in education curriculum in some remote schools, as well as in other family programs and early learning settings (e.g. the NT's Families as First Teachers program) to sustain messaging outside of screening and treatment programs. Collaboration is increasingly occurring with other environmental-related disease programs (e.g. ear, dental, and skin health), enabling holistic approaches to health promotion.

Environmental improvement activities

Information available on environmental improvement activities is based on narrative reporting of program activities by jurisdictions and local partners. There is currently no agreed national/international monitoring and evaluation framework to support a more systematic approach to reporting of environmental health and housing conditions, interventions and impacts at the community, regional, and national levels. Jurisdictional-level trachoma programs collaborate with environmental and housing programs but are not in a position to comprehensively monitor their activities.

Reported activities undertaken in 2024 to improve environmental conditions in trachoma endemic regions have included:

Inspections of home health hardware by environmental health workers in remote communities, also known as 'Healthy Homes assessments'. Assessments are accompanied by home environment remediation activities including the distribution of hygiene resources, hard rubbish removal, the provision of plumbing, electrical and carpentry maintenance, and pest management, or referral for these services as required. Collaboration between environmental health and trachoma control/clinical programs to co-deliver interventions ensures that improvements address underlying contributors to disease.

Installation and refurbishment of hygiene equipment in local schools and communities (e.g. handwashing stations) in trachoma affected regions to support regular practice.

Workforce capacity building such as training/upskilling of Aboriginal Environmental Health Workers and development of environmental health positions in primary healthcare settings to enhance joined-up care.

Environmental health policy advice, strategic planning, guidance, and resource development continues to be undertaken by the Expert Reference Panel on Aboriginal and Torres Strait Islander Environmental Health under the Environmental Health Standing Committee (enHealth) of the Australian Health Protection Committee, as well as by other jurisdictional and regionally based committees.

Future considerations

It is important to note that 'elimination as a public health problem' as defined by WHO does not equate to the complete absence of new infections. Trachoma prevalence remains well above 5% in several

communities and indicates both ongoing risk and the potential for resurgence of infection elsewhere. Should Australia's elimination dossier be approved by WHO, ongoing surveillance and treatment activities for trachoma management will need to continue. Systems for trachoma surveillance post-validation are currently being explored. The current method of training internationally accredited graders may not be sustainable as prevalence continues to decline. In addition, TF correlates poorly with current infection in low prevalence settings.⁴¹ Options for supplementary laboratory-based surveillance such as via serological markers are currently being investigated for suitability in Australian contexts. Crucially, these activities must be conducted under the guidance and with direct involvement of the affected communities and community-controlled health services.

Sustaining elimination of trachoma as a public health problem relies on strengthening health promoting environments, particularly improving the provision of appropriate housing in remote areas and ongoing maintenance of home health hardware, including water and sanitation facilities. Environmental health improvements have health benefits that go well beyond trachoma control, but require a multi-sectoral effort, involving agencies beyond the public health units and teams that traditionally have been assigned responsibility for trachoma control activities. The NTSCRG has extended the number of environmental health and housing representatives in its membership to advance ongoing cross-sectoral collaboration.

National results

Figures and Tables

Figure 1.1 Overall trachoma prevalence in children aged 5–9 years by jurisdiction, Australia, 2024

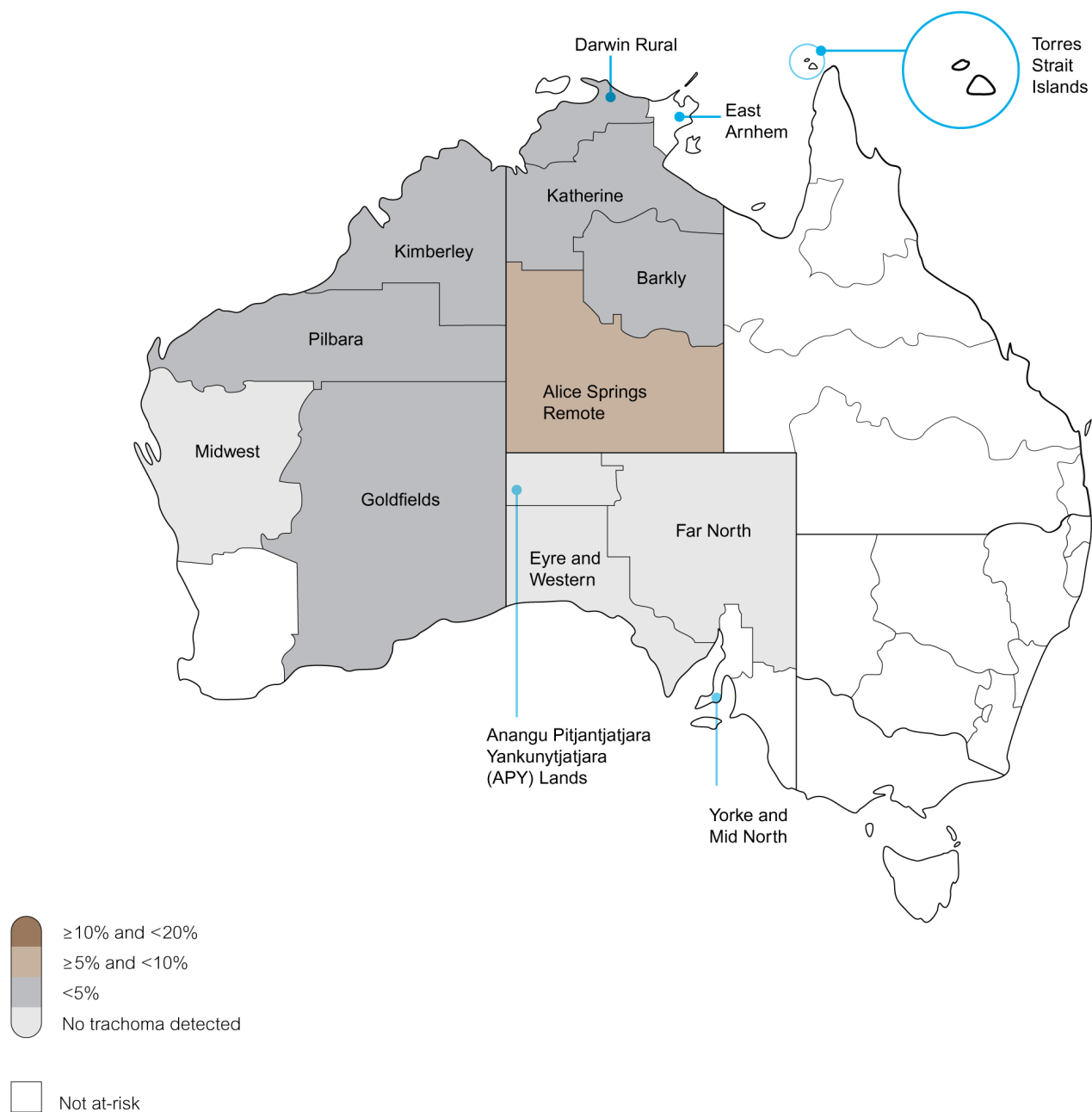
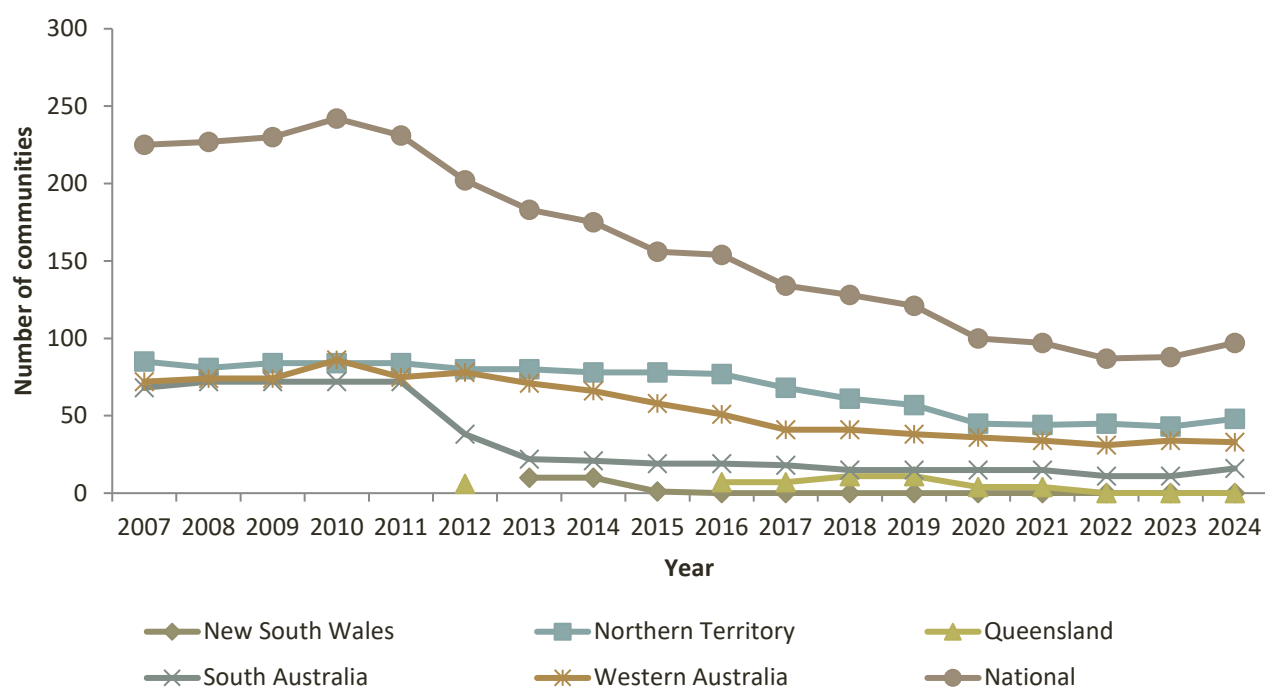


Figure 1.2 Number of at-risk communities* by jurisdiction, Australia, 2007–2024



* 2024 data points include communities identified by selected jurisdictions for evidence confirmation screening for final-year dossier validation surveillance (refer to Findings and interpretation).

Figure 1.3 Number of at-risk communities according to trachoma control strategy implemented by jurisdiction, Australia, 2024



Figure 1.4 Proportion of screened children aged 5–9 years who had a clean face by jurisdiction, Australia 2007–2024

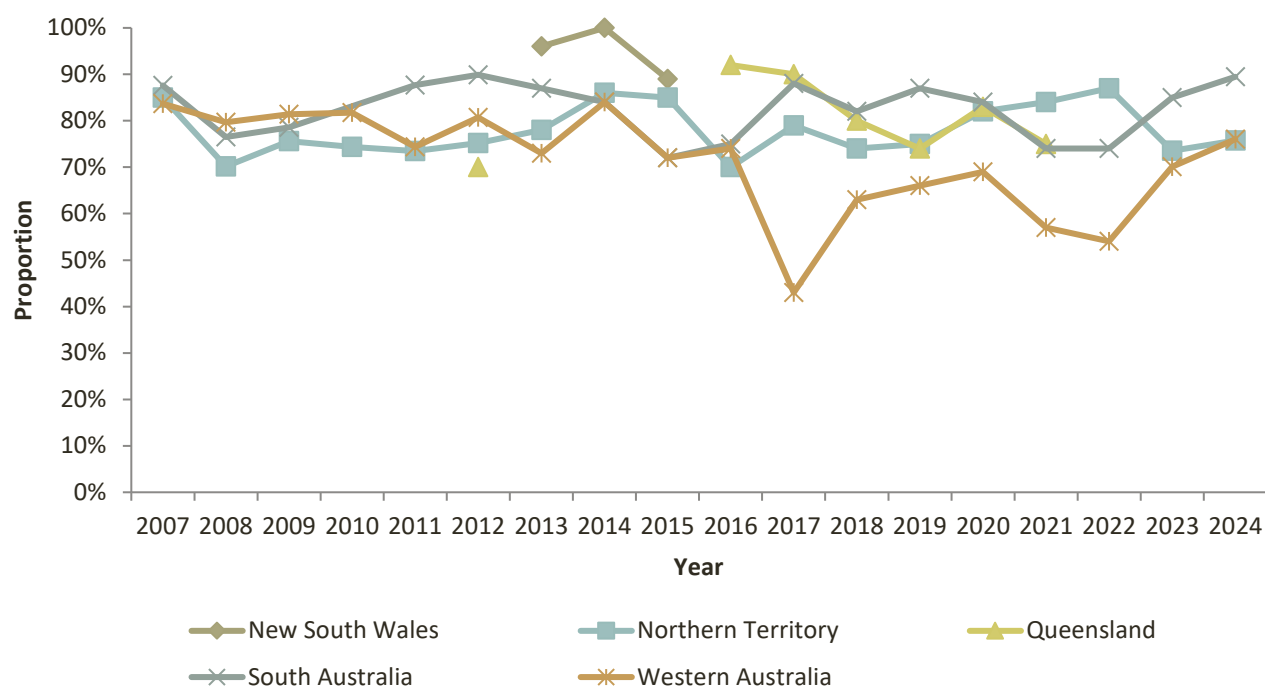
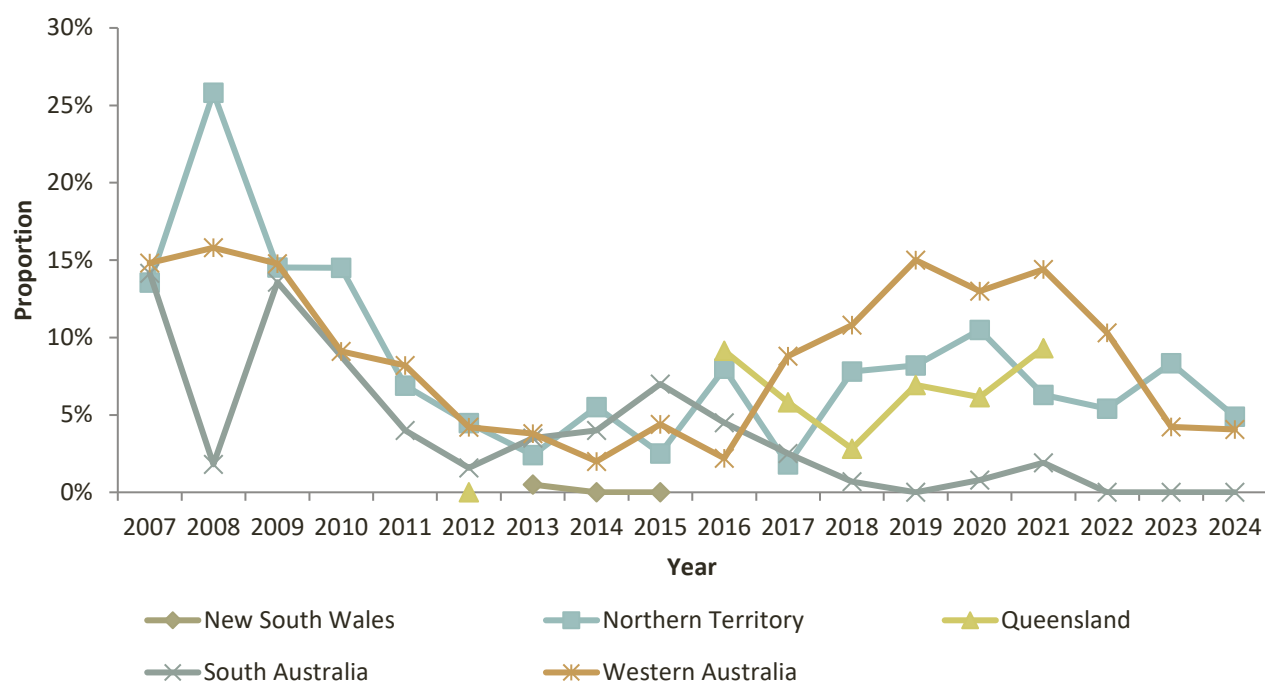
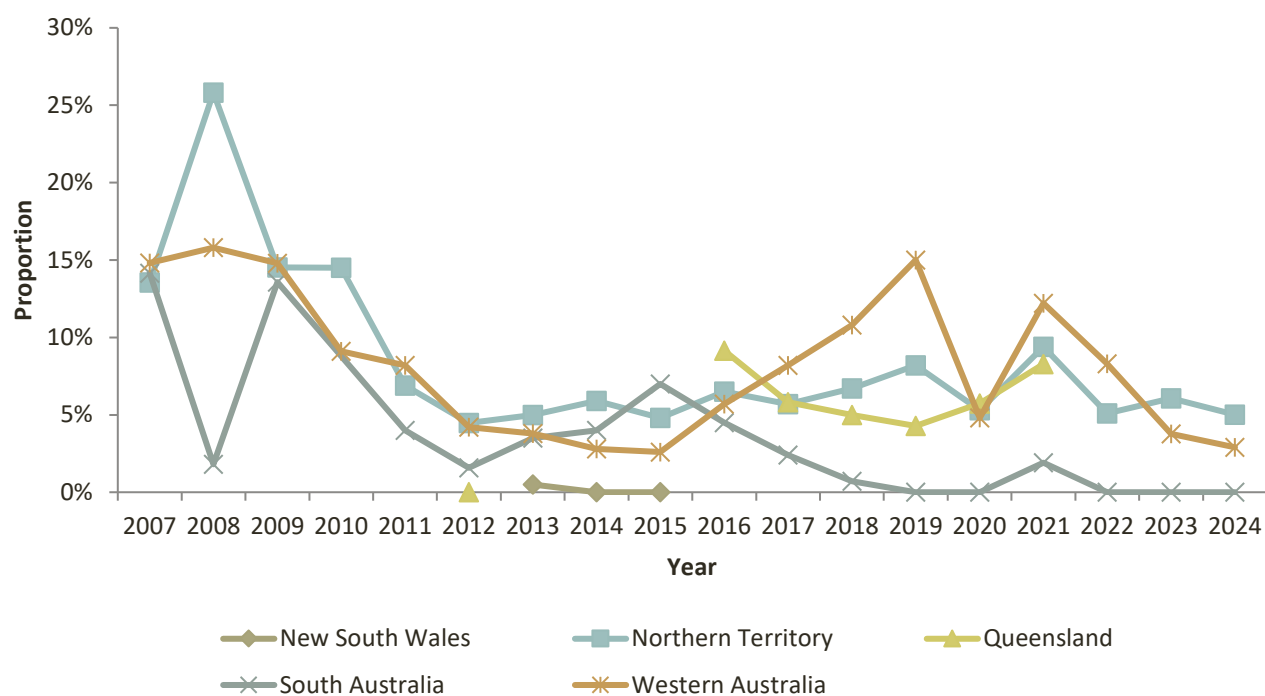


Figure 1.5a Observed prevalence of clinical findings consistent with trachomatous inflammation—follicular/intense* among screened children aged 5–9 years by jurisdiction, Australia, 2007–2024



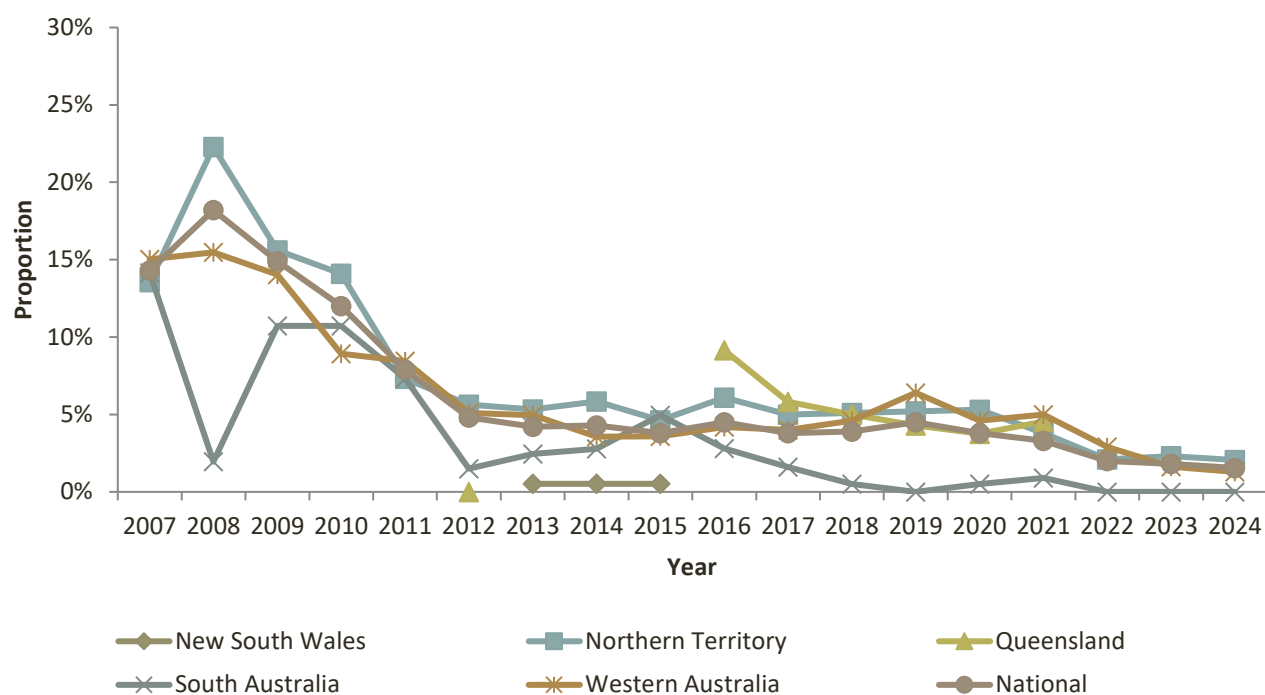
*According to WHO simplified trachoma grading criteria²

Figure 1.5b Estimated prevalence of trachoma among children aged 5–9 years in all at-risk communities* by jurisdiction, Australia, 2007–2024



* Most recent estimates carried forward in at-risk communities that did not screen in 2024.

Figure 1.5a Overall prevalence of trachoma among children aged 5–9 years in all communities* by jurisdiction, Australia, 2007–2024



* Calculated carrying forward most recent data in all communities considered at risk of trachoma at any point since 2007.

Figure 1.6 Number of screened at-risk communities according to the level of observed trachoma prevalence in children aged 5–9 years by jurisdiction, Australia, 2024

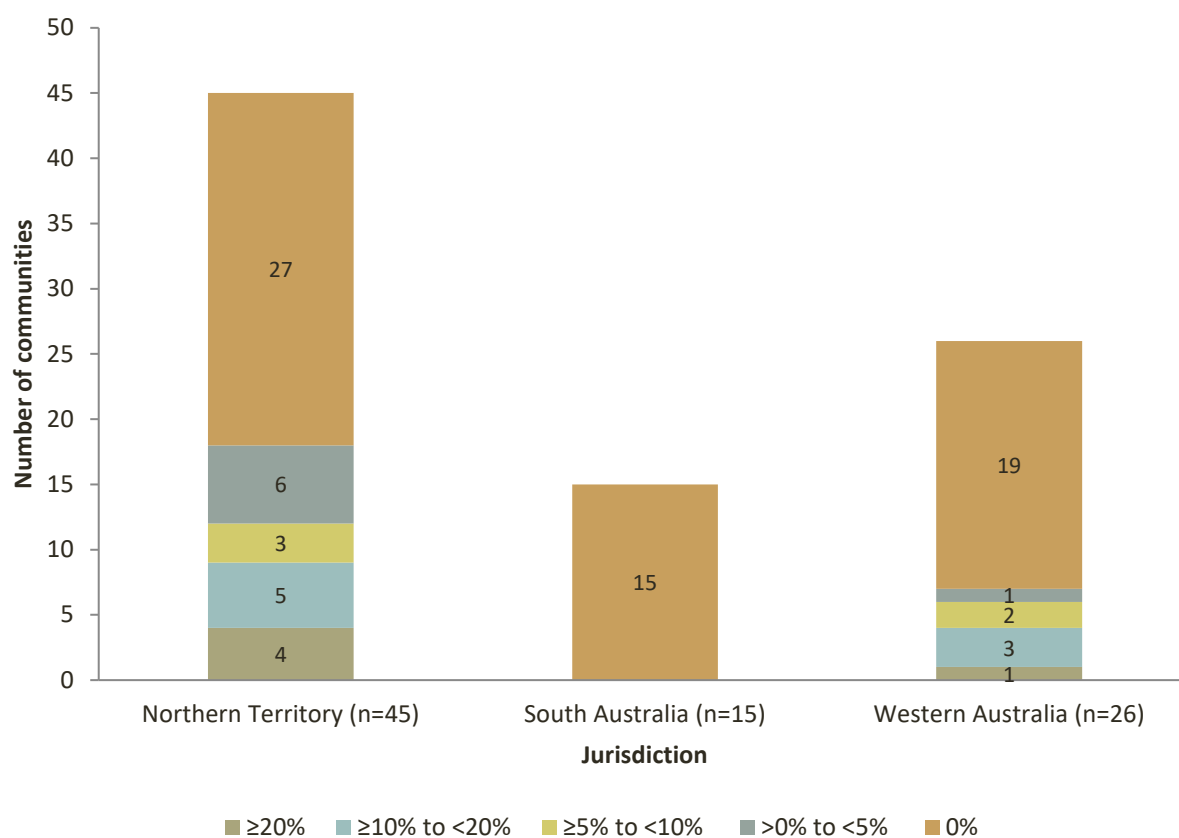


Figure 1.7 Proportion of screened at-risk communities with no observed trachoma by jurisdiction, Australia, 2007–2024

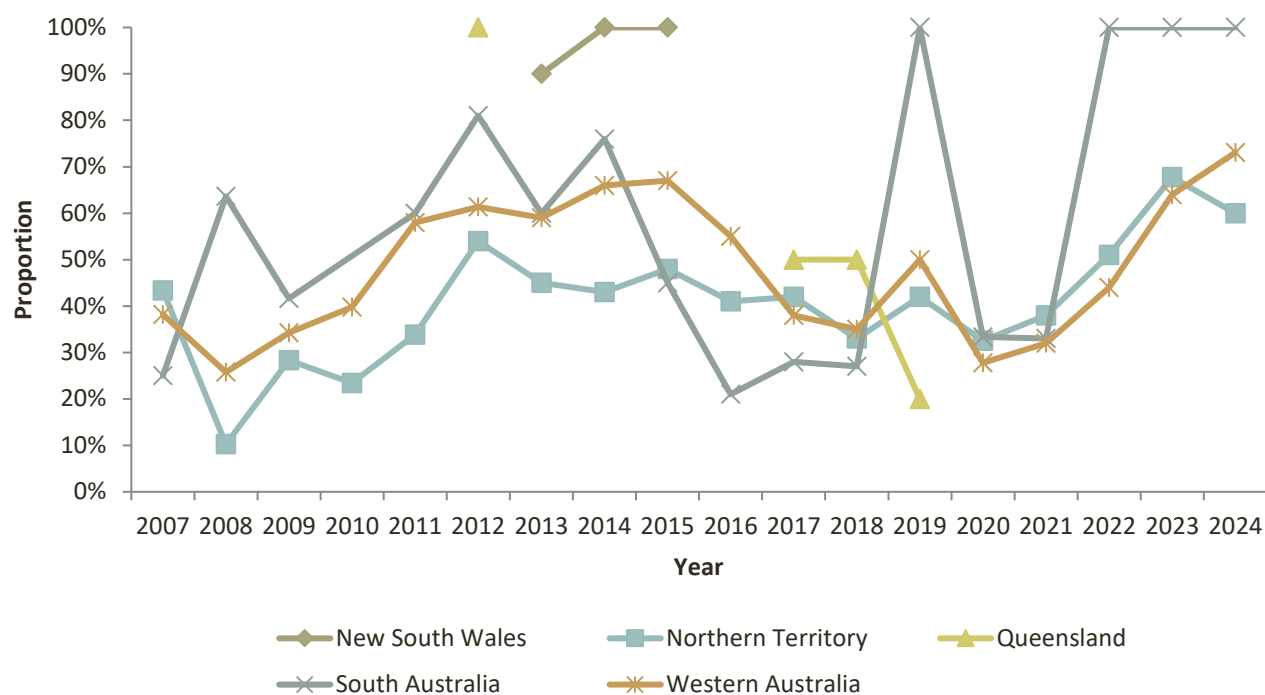


Figure 1.8 Proportion of screened at-risk communities with observed endemic levels of trachoma ($\geq 5\%$) by jurisdiction, Australia, 2007–2024



Figure 1.9 Number of doses of azithromycin administered for the treatment of trachoma by jurisdiction, Australia, 2007–2024

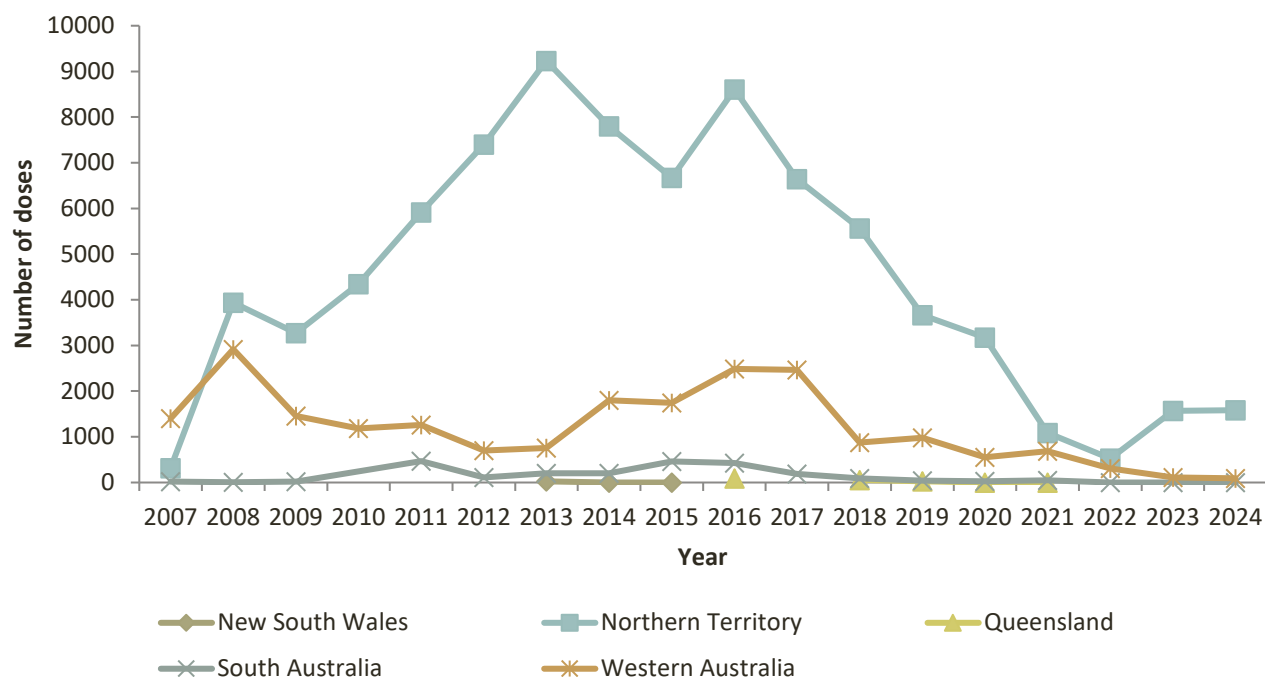


Table 1.1 Trachoma control delivery in at-risk communities by jurisdiction, Australia, 2024

Number of communities	Northern Territory	South Australia	Western Australia	Total
At risk (A)*	48	16	33	97
Requiring screening for trachoma (B)	48	16	26	90
Screened for trachoma (C)	45	15	26	86
Requiring treatment without screening† (D)	0	0	0	0
Received treatment without screening (E)	0	0	0	0
Screened and/or treated for trachoma (F=C+E)	45	15	26	86
Requiring neither screening nor treatment for trachoma (G=A-B-D)	0	0	7	7

* As defined by each jurisdiction, including communities identified for evidence confirmation screening for final-year dossier validation surveillance (refer to Findings and interpretation).

† As per CDNA Guidelines.

Table 1.2 Trachoma screening coverage, trachoma prevalence, and clean face proportion in children aged 5–9 years by jurisdiction, Australia, 2024

	Northern Territory	South Australia	Western Australia	Total
Number of communities screened	45	15	26	86
Estimated number* of Aboriginal children in communities	1309	490	320	2119
Children examined for clean face	1252	436	296	1984
Children with clean face	948	390	225	1563
<i>Clean face (%)</i>	76	89	76	79
Children screened for trachoma	1144	446	295	1885
<i>Trachoma screening coverage (%)</i>	87	91	92	89
Children with active trachoma	56	0	12	68
<i>Observed prevalence of active trachoma† (%)</i>	4.9	0	4.1	3.6
<i>Estimated prevalence of active trachoma‡ (%)</i>	5.0	0	2.9	3.5
<i>Overall prevalence of active trachoma (%)</i>	2.1	0	1.3	1.5

* Jurisdictional estimate.

† Communities that were screened for trachoma in 2024.

‡ Prevalence rate calculations are described in the Methodology section.

Table 1.3 Number and proportion of at-risk communities according to the level of observed trachoma prevalence in children aged 5–9 years, Australia, 2014–2024

	2014		2015		2016		2017		2018		2019		2020		2021		2022		2023		2024	
Communities at-risk*	175		156		154		134		129		121		100		97		87		88		97	
At-risk communities not screened or treated without screening †	41		80		46		49		35		11		6		15		8		21		11	
At-risk communities screened	134		76		108		85		94		110		94		82		79		67		86	
Observed prevalence (screened communities only) ‡	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion
≥20%	13	10%	9	12%	10	9%	9	11%	14	15%	24	22%	17	18%	10	12%	10	13%	5	7%	5	6%
≥10% to <20%	16	12%	6	8%	15	14%	18	21%	18	19%	14	13%	27	29%	18	22%	12	15%	8	12%	8	9%
≥5% to <10%	4	3%	12	16%	15	14%	6	7%	11	12%	9	8%	11	12%	13	16%	9	11%	4	6%	5	6%
>0% to <5%	13	10%	8	11%	18	17%	17	20%	15	16%	8	7%	12	13%	13	16%	4	5%	2	3%	7	8%

	2014		2015		2016		2017		2018		2019		2020		2021		2022		2023		2024	
0%	88	66%	41	54%	50	46%	35	41%	36	38%	55	50%	27	29%	28	34%	44	56%	48	72%	61	71%

* As defined annually by each jurisdiction.

† As per CDNA Guidelines. Includes communities that were not screened due to logistical or demographic reasons (i.e., no children in the 5–9-year age group).

‡ If more than one screening episode occurs during the calendar year, data from the first screen is used.

Table 1.4 Treatment strategies by jurisdiction, Australia, 2024

Number of communities	Northern Territory	South Australia	Western Australia	Total
Required antibiotic treatment for trachoma	18	0	7	25
Treated for trachoma	18	0	7	25
Screened and treated	18	0	7	25
Received treatment only	0	0	0	0
Received 6-monthly treatment	0	0	0	0
Did not require treatment	27	15	19	61
Treated active trachoma and household contacts	12	0	7	19
Community-wide treatment	6	0	0	6
Not treated according to CDNA Guidelines	0	0	0	0

Table 1.5 Antibiotic distribution and coverage by age and jurisdiction, Australia, 2024

	Northern Territory					Western Australia					Total				
Age group (years)	0–4	5–9	10–14	15+	All	0–4	5–9	10–14	15+	All	0–4	5–9	10–14	15+	All
Requiring treatment for active trachoma	1	56	3		60	0	12	0		12	1	68	3		72
Received treatment for active trachoma	1	53	3		57	0	12	0		12	1	65	3		69
Received treatment for active trachoma (%)	100	95	100		95	N/A	100	N/A		100	100	96	100		96
Estimated community members* requiring treatment	275	300	351	2012	2938	11	14	14	55	94	286	314	365	2067	3032
Number of community members who received treatment	137	206	170	1012	1525	11	13	13	43	80	148	219	183	1055	1605
<i>Estimated community members who received treatment (%)</i>	50	69	48	50	52	100	93	93	78	85	52	70	50	51	53
Number of community members that refused treatment	11	7	12	86	116	0	1	1	11	13	11	8	13	97	129
Total number of doses of azithromycin delivered	138	259	173	1012	1582	11	25	13	43	92	149	284	186	1055	1674
<i>Estimated overall treatment coverage (%)</i>	50	73	49	50	53	100	96	93	78	87	52	74	51	51	54

* Estimated as per CDNA Guidelines.

Table 1.6 Trachomatous trichiasis (TT) screening coverage, TT screened proportion, and surgery among Indigenous persons by jurisdiction, Australia, 2024

	Northern Territory		South Australia		Western Australia		Queensland		Total		
Number of communities screened for TT	89		13		62		1		165		
Age group (years)	15–39	40+	15–39	40+	15–39	40+	15–39	40+	15–39	40+	15+
Adults examined*	7720	7556	438	616	45	2268	145	143	8348	10583	18931
With TT †	0	5	0	3	0	0	0	1	0	9	9
<i>With TT (%)</i>	<i>0.00</i>	<i>0.07</i>	<i>0.00</i>	<i>0.49</i>	<i>0.00</i>	<i>0.00</i>	<i>0.00</i>	<i>0.70</i>	<i>0.00</i>	<i>0.09</i>	<i>0.05</i>
Surgery in past 12 months‡	0	2	0	0	0	4	0	0	0	6	6

* This number may not account for all adults who may be examined in routine adult health checks and may also include multiple screenings per patient. Screening is linked to trachoma endemic regions and does not consider changing endemic regions over time and transiency between regions.

† Defined as cases 'previously unknown to the health system'.

‡ Surgery may include cases identified in previous years.

Jurisdictional-specific results

Northern Territory results

Trachoma program coverage

In 2024, the NT identified 48 communities across four regions as requiring screening for trachoma (Figure 2.2, Table 2.1). This includes eight communities previously removed from the at-risk register with population linkages to current at-risk communities as well as five at-risk communities not due for screening in 2024 under current guidelines that were added to the screening plan as part evidence confirmation for final-year dossier validation surveillance.

Of the 48 communities requiring screening, 45 of these were screened (94%) (Figure 2.3, Table 2.1).

Trachoma screening coverage

The total proportion of children aged 5–9 years screened across these 45 communities was 87% (1144/1309). There was little variation in trachoma screening coverage between the Alice Springs Remote, Barkly, and Katherine regions, which had larger populations at risk (Table 2.2).

Facial cleanliness

Facial cleanliness was assessed in all communities that were screened in 2024 (data not shown).

The total proportion of clean faces among children aged 5–9 years in the communities assessed across the NT was 76% (948/1252). Proportions were higher in the Katherine region at 87% compared to the Barkly and Alice Springs Remote regions at 72% and 71% respectively (Figure 2.4, Table 2.2).

Trachoma prevalence

The observed prevalence of trachoma in those aged 5–9 years in the 45 communities that were screened in 2024 was 4.9% (56/1,144). Observed prevalence ranged from 10.4% in the Katherine region to 0.4% in the Barkly region (Figure 2.5a, Table 2.2).

No trachoma was reported in 27/45 (60%) of the screened at-risk communities (Figure 2.6, Table 2.3).

Endemic trachoma (observed prevalence $\geq 5\%$) was reported in 12/45 (27%) of the screened at-risk communities (Figure 2.6, Table 2.3)

Hyperendemic trachoma (observed prevalence $\geq 20\%$) was reported in 4/45 (9%) of the screened at-risk communities (Figure 2.6, Table 2.3).

The overall prevalence of trachoma (which includes data from all communities ever considered at risk of trachoma) in those aged 5–9 years was 2.1% in 2024. Overall prevalence ranged from 0.4% in the Darwin Rural region to 5.0% in the Alice Springs Remote region (Figure 2.5c, Table 2.2).

Treatment delivery and coverage

Trachoma treatment was required and provided in 18 communities (Table 2.4).

Treatment was delivered to trachoma cases and household contacts in 12 communities, and treatment was undertaken community-wide in six communities as per CDNA Guidelines (Table 2.4).

The highest number of azithromycin doses administered was in the Katherine region (797 doses), followed by Alice Springs Remote (763 doses). Treatment coverage in these regions was 45% and 63% respectively (Figure 2.7, Table 2.5).

Trachomatous Trichiasis (TT)

TT screening was undertaken in 89 communities, with 15,276 persons aged 15 years and older reported to be screened (Table 2.6).

There were five cases of TT detected among those screened in 2024 (0.03%) (Table 2.6).

Surgery for TT was reported to be undertaken for two persons aged 15 years or over (Table 2.6).

Health promotion

In 2024, 107 facial cleanliness health promotion activities were delivered across 37 communities (Table 2.7). Activities are conducted via collaboration among multiple stakeholders, including NT Health Trachoma Program, ACCHSs, Indigenous Eye Health Unit (IEHU), Regional Councils, NT Department of Education and Training, and NT Department of Housing, Local Government and Community Development. Where practical, health promotion activities are conducted in conjunction with trachoma screening to reinforce key messages and assist with building relationships between community members and clinical staff. Key achievements in 2024 include:

Milpa the Goanna and the “Clean Face, Strong Eyes” messaging continue to be widely recognised in Aboriginal communities. Milpa appeared in costume 21 times in 2024, with the program expanding the use of new interactive technology methods such as smartphone apps during screening and health promotion activities to enhance engagement.

NT Health Trachoma Program nurses partnered with the Department of Education and Training to maximise coverage and assist in improving health literacy regarding trachoma and other preventable, communicable conditions in school settings. Several schools have incorporated “Clean Face, Strong Eyes” into their daily class routine, complimenting the “Blow, Breath, Cough” regime of Hearing Australia to prevent otitis media.

Over 600 hygiene packs were distributed in Milpa branded bags, which included personal towels and hygiene products to assist children to complete the *Six Steps to Stop Germs*. These proved to be extremely popular, and there are plans to increase distribution in 2025.

NT Health gifted water, sanitation, and hygiene (WASH) trailers to enable hand and face washing at community events including the Tidy Towns Health Expo with MacDonnell Regional Council and Healthy Home Connect event with Central Desert Regional Council, as well as during regular screening trips.

The partnership between IEHU and the Melbourne Football Club continued with staff and players from the club joining health promotion and community education and engagement activities in Central Australia. A highlight was the Melbourne Football Club match in Alice Springs, which provided opportunity to engage with a broad range of community members and stakeholders.

Environmental Health

Healthy Housing Officer program

This program has continued in Central Australia (Alice Springs) and Katherine regions from 2023. Officers visit community homes and undertake a comprehensive audit of home health hardware. Community requests for repairs/maintenance are electronically forwarded to the relevant local/territory authority for joint communication and follow-up. Auditing activities are supported by capacity building training sessions for services working with families in remote communities. The program is a collaboration between NT Health Trachoma Program, NT Environmental Health Central Australia team, MacDonnell and Central Desert Regional Councils, Central Australian Aboriginal Congress, and Katherine West Health Board. It is funded by Fred Hollows Foundation, Rotary Districts of Australia, and IEHU.

Housing Officers and program partners were invited to jointly present on the work of the program at three conferences in 2024: the Aboriginal Housing and Homelands Conference (Alice Springs), the National Aboriginal and Torres Strait Islander Environmental Health Conference (Melbourne), and the National Aboriginal and Torres Strait Islander Eye Health Conference (Nipaluna, Hobart).

Environmental health improvement in schools

NT Trachoma Program utilised the IEHU's SAFE Bathroom Checklist to aid discussion with school students and teachers about the importance of functioning health hardware in homes to prevent disease. This included helping school staff to make improvements to cleanliness and infrastructure accessibility in areas where children wash their hands, faces, and brush their teeth within the school. For example, the program provided 18 acrylic mirrors to 10 schools in Central Australia in 2024.

Environmental health workforce development project

In 2024, the NT Health Trachoma Program continued to fund a grant to Aboriginal Medical Services Alliance Northern Territory, the peak governing body for NT ACCHS. This working partnership aims to co-design a community primary health clinic-based environmental health workforce. Stage 1 involves the development and costing of a pilot project proposed to be implemented in two communities. Project development includes role definition, identifying training and mentoring opportunities, as well as designing the employment model, management structure, data collection systems, and evaluation. An expert panel to guide development has been appointed, including environmental health experts and researchers, primary and public health clinicians, Aboriginal health professionals, and workforce specialists. Funding opportunities are currently being explored to commence the initiative.

As a subset of this initiative, NT Health Trachoma Program has supported a Master of Applied Epidemiology student to develop automated reports of presentations to NT Government remote primary health care clinics related to poor environmental conditions. These reports will be used in the future to monitor levels of presentations of trachoma and other environmentally attributable conditions, and to evaluate the impact of the workforce development project.

Coordination

National Partnership Agreement for Remote Housing Joint Steering Committee: the NT Health Trachoma Program was invited to join the Design and Procurement Working Group of the Joint Steering Committee to enhance intersectoral collaboration between health and housing sectors. This group focuses on improving community control over house design, enhanced specifications for health hardware, as well as

increasing access to better performing WASH facilities, greater thermal comfort, and better indoor air quality in homes. Other members include Aboriginal Housing NT, Land Councils, National Indigenous Australians Agency, NT Department of Housing, Local Government and Community Development, and the NT Department of Logistics and Infrastructure.

NT Trachoma Group has a Central Australian focus and was historically run by the NT Health Trachoma Program. Administration has now transferred to the Fred Hollows Foundation. The NT Trachoma Group meets monthly and brings together key organisations working in the trachoma space, providing a platform for information sharing and coordination of remote trips, activities, and resources.

Central Australia Environmental Health Working Group is based in Central Australia and Barkly, with coordination provided by IEHU. Members include the NT Government Departments of Health, Education, Housing and Infrastructure, Aboriginal Medical Services Alliance Northern Territory and its local member organisations, and regional councils. The group meets quarterly to share information, coordinate, and support environmental improvement projects in remote communities to eliminate trachoma. In 2024, the group has concentrated on advocacy around improving health hardware maintenance and reducing crowding in remote communities.

Figures and Tables – Northern Territory

Figure 2.1 Overall trachoma prevalence in children aged 5–9 years by region, Northern Territory, 2024

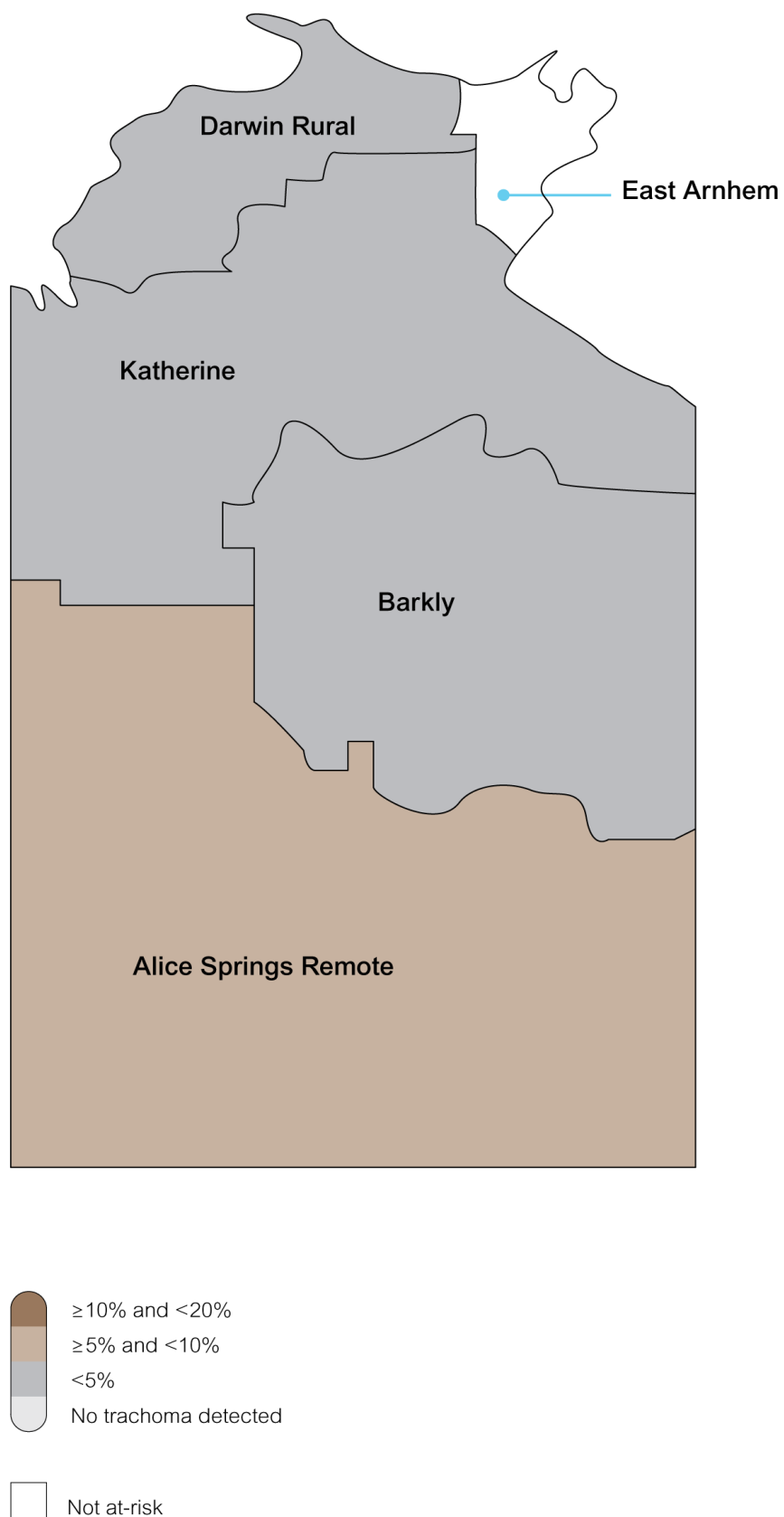
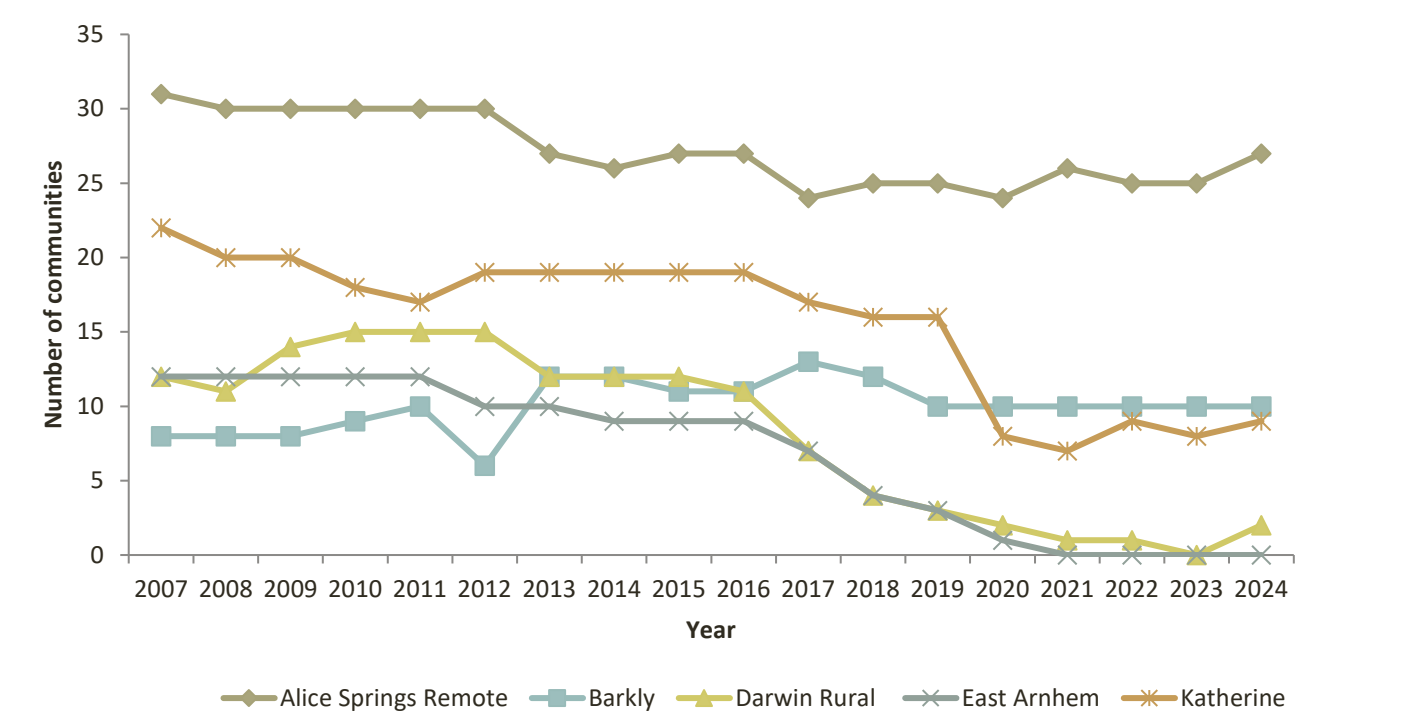


Figure 2.2 Number of at-risk communities* by region, Northern Territory, 2007–2024



* 2024 data points include communities identified for evidence confirmation screening for final-year dossier validation surveillance (refer to Findings and interpretation).

Figure 2.3 Number of at-risk communities according to trachoma control strategy implemented by region, Northern Territory, 2024

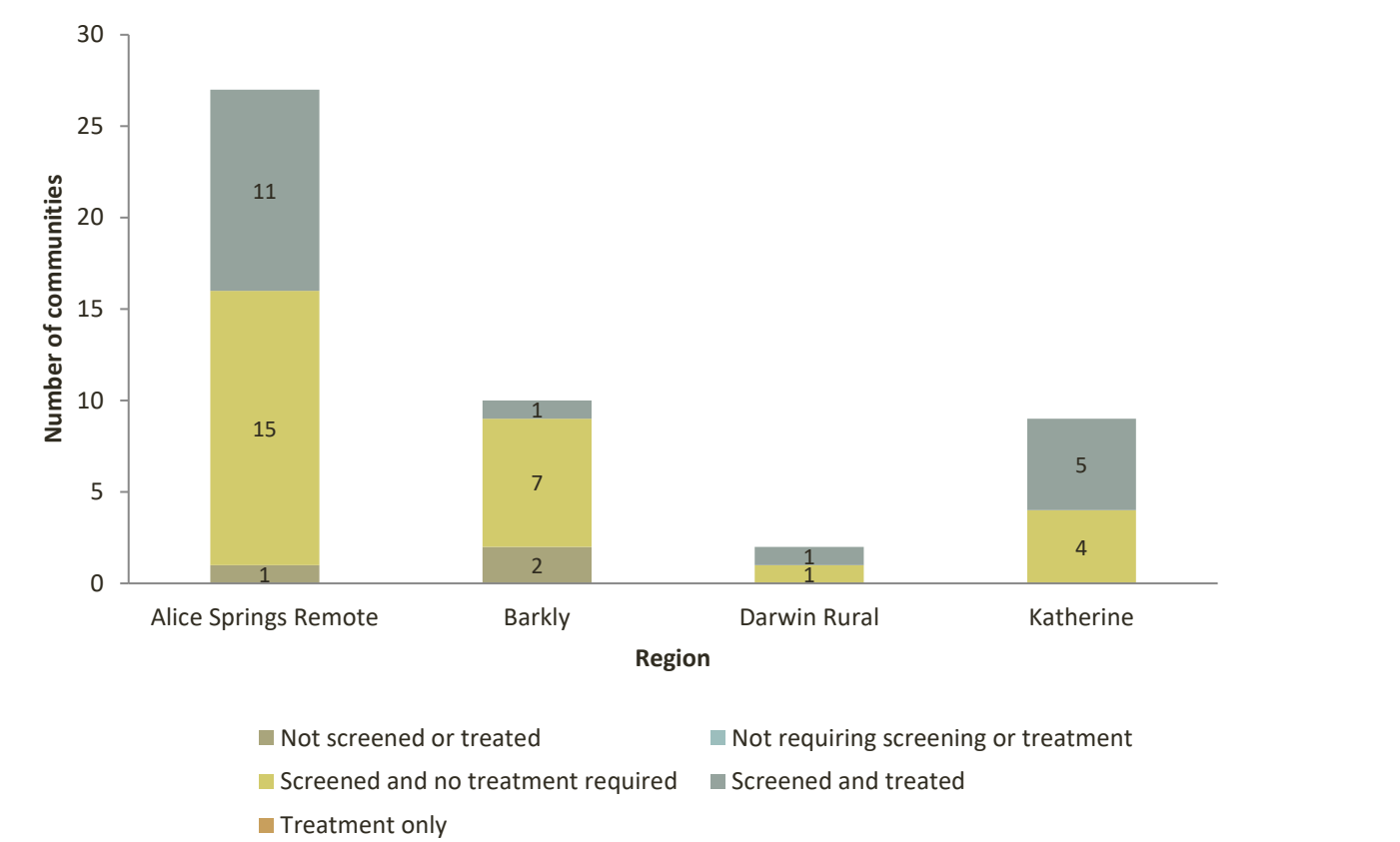


Figure 2.4 Proportion of screened children aged 5–9 years who had a clean face by region, Northern Territory, 2007–2024

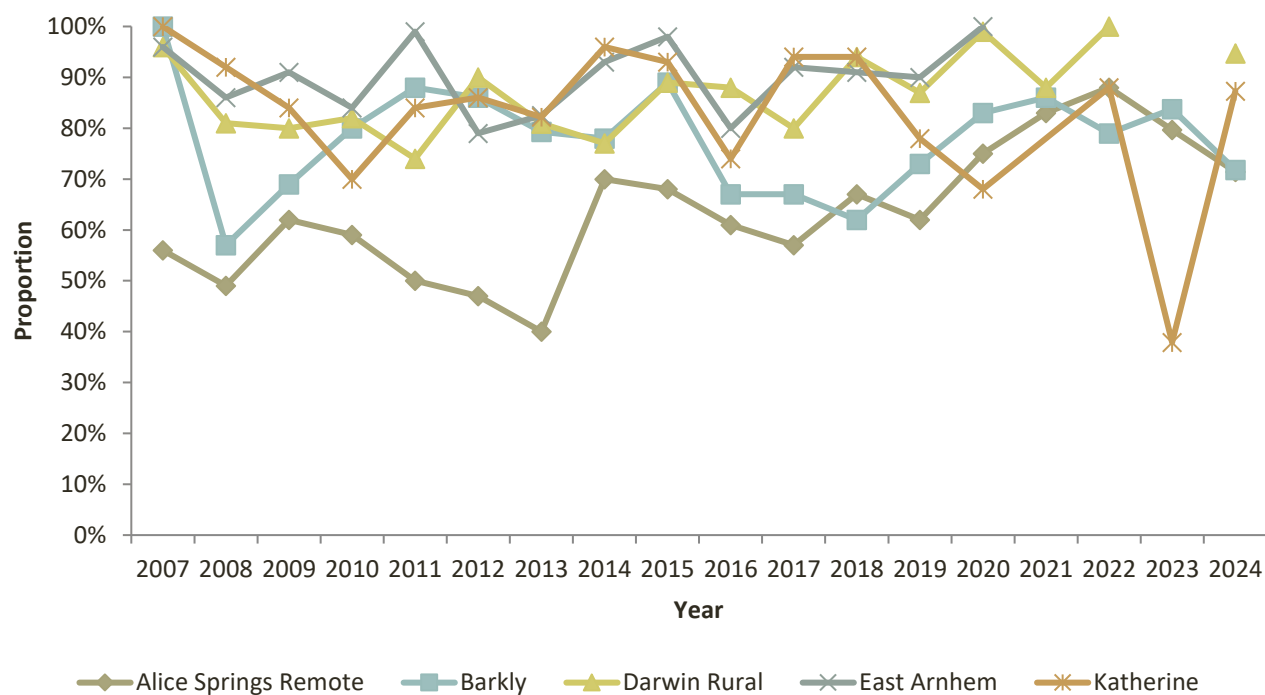
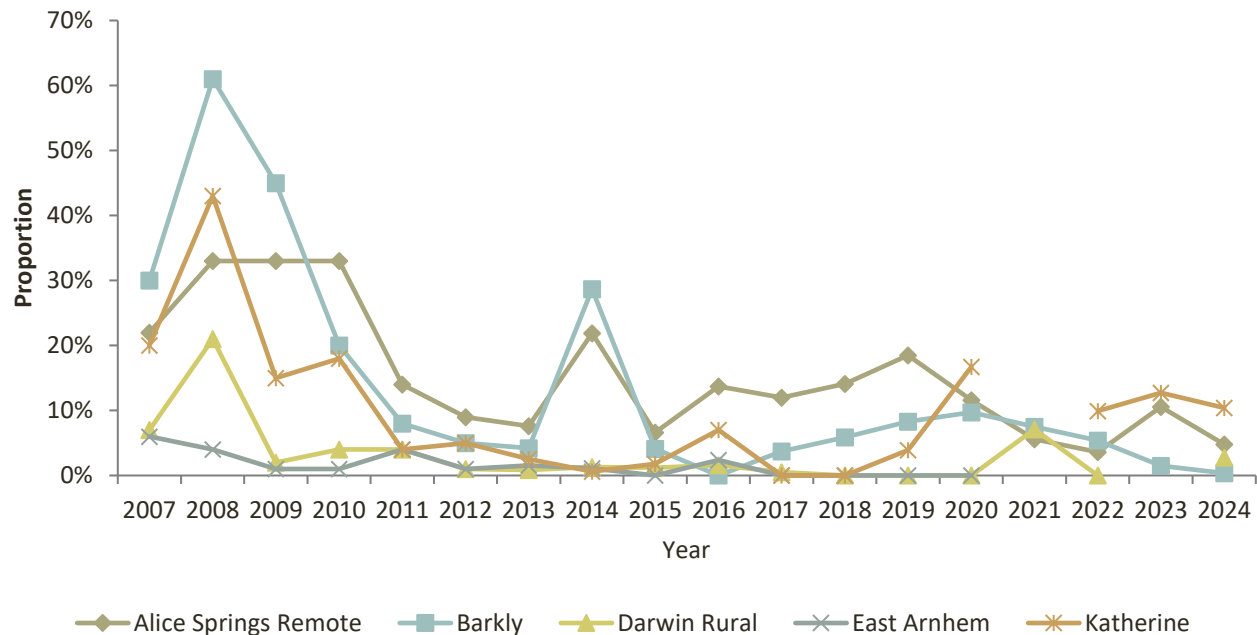
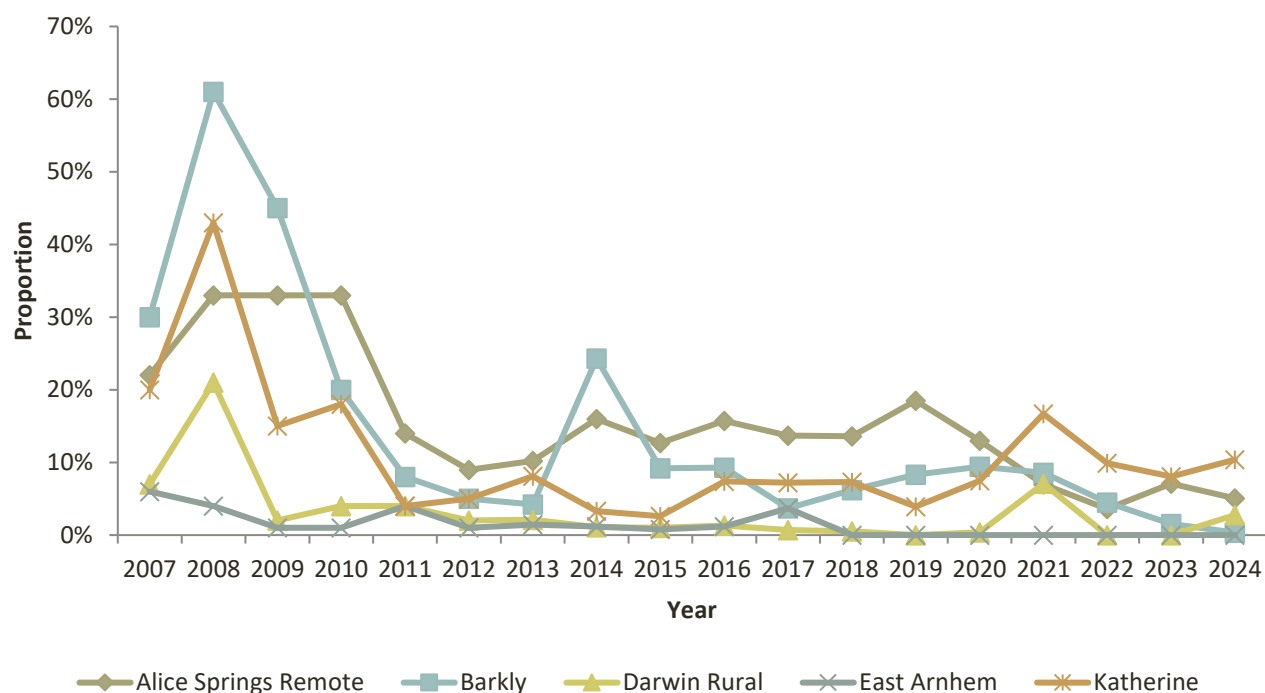


Figure 2.5a Observed prevalence of clinical findings consistent with trachomatous inflammation—follicular/intense* among screened children aged 5–9 years by region, Northern Territory, 2007–2024



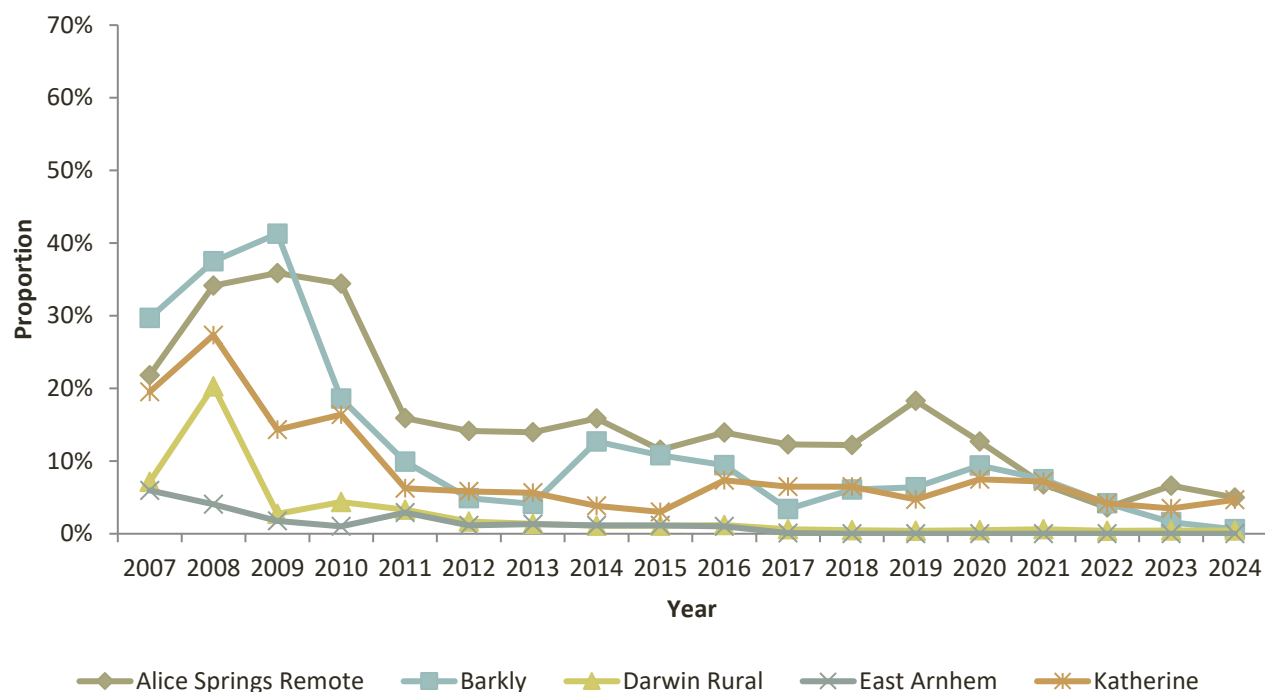
*According to WHO simplified trachoma grading criteria²

Figure 2.5b Estimated prevalence of trachoma among children aged 5–9 years in all at-risk communities* by region, Northern Territory, 2007–2024



* Most recent estimates carried forward in at-risk communities that did not screen in 2024.

Figure 2.5c Overall prevalence of trachoma among children aged 5–9 years in all communities* by region, Northern Territory, 2007–2024



* Calculated carrying forward most recent data in all communities considered at risk of trachoma at any point since 2007.

Figure 2.6 Number of screened at-risk communities according to the level of observed trachoma prevalence in children aged 5–9 years by region, Northern Territory, 2024

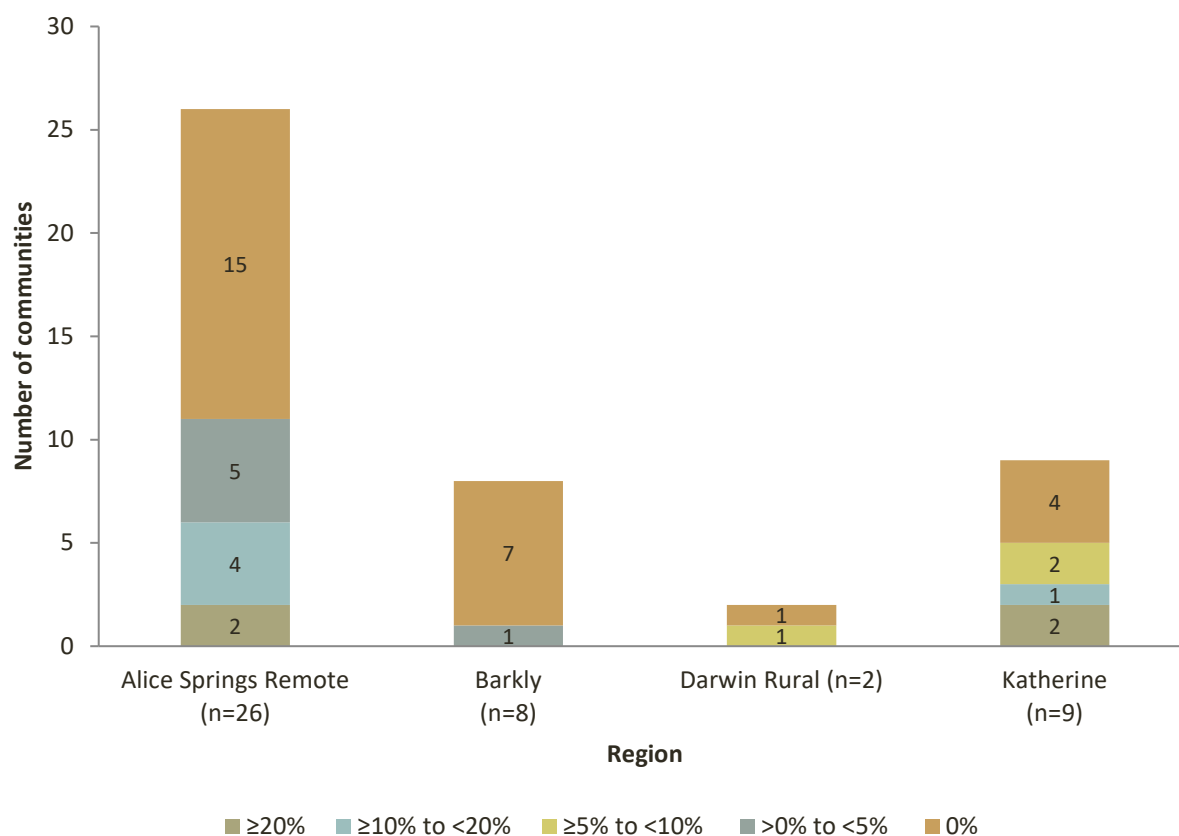


Figure 2.7 Number of doses of azithromycin administered for the treatment of trachoma by region, Northern Territory, 2007–2024

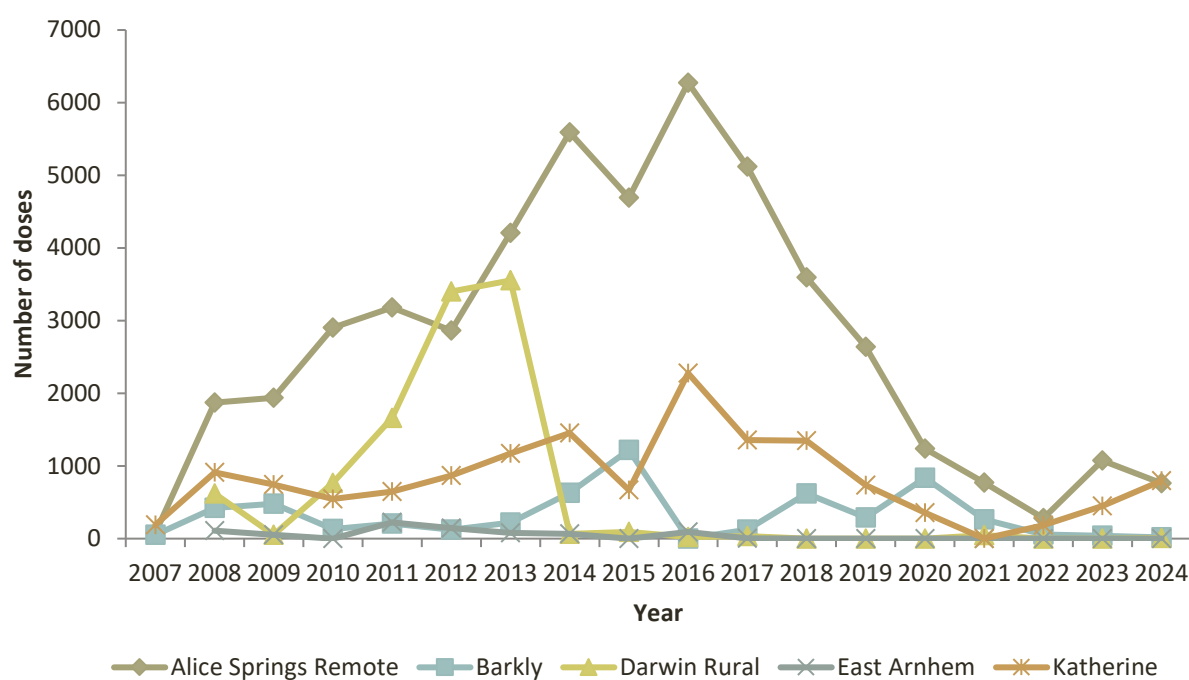


Table 2.1 Trachoma control delivery in at-risk communities by region, Northern Territory, 2024

Number of communities	Alice Springs Remote	Barkly	Darwin Rural	Katherine	Total
At risk (A)*	27	10	2	9	48
Requiring screening for trachoma (B)	27	10	2	9	48
Screened for trachoma (C)	26	8	2	9	45
Requiring treatment without screening† (D)	0	0	0	0	0
Received treatment without screening (E)	0	0	0	0	0
Screened and/or treated for trachoma (F=C+E)	26	8	2	9	45
Requiring neither screening nor treatment for trachoma (G=A-B-D)	0	0	0	0	0

* As defined by each jurisdiction, including communities identified for evidence confirmation screening for final-year dossier validation surveillance (refer to Findings and interpretation).

† As per CDNA Guidelines.

Table 2.2 Trachoma screening coverage, trachoma prevalence, and clean face proportion in children aged 5–9 years by region, Northern Territory, 2024

	Alice Springs Remote	Barkly	Darwin Rural	Katherine	Total
Number of communities screened	26	8	2	9	45
Estimated number* of Aboriginal children in communities	653	327	38	291	1309
Children examined for clean face	634	305	38	275	1252
Children with clean face	453	219	36	240	948
<i>Clean face (%)</i>	71	72	95	87	76
Children screened for trachoma	565	283	36	260	1144
<i>Trachoma screening coverage (%)</i>	87	87	95	89	87
Children with active trachoma	27	1	1	27	56
<i>Observed prevalence of active trachoma† (%)</i>	4.8	0.4	2.8	10.4	4.9
<i>Estimated prevalence of active trachoma‡ (%)</i>	5.0	0.3	2.8	10.4	5.0
<i>Overall prevalence of active trachoma (%)</i>	5.0	0.6	0.4	4.7	2.1

* Jurisdictional estimate.

† Communities that were screened for trachoma in 2024.

‡ Prevalence rate calculations are described in the Methodology section.

Table 2.3 Number and proportion of at-risk communities according to the level of observed trachoma prevalence in children aged 5–9 years, Northern Territory, 2014–2024

	2014		2015		2016		2017		2018		2019		2020		2021		2022		2023		2024	
Communities at-risk*	78		78		77		68		61		57		45		44		45		43		48	
At-risk communities not screened or treated without screening†	31		37		27		39		26		2		2		7		4		12		3	
At-risk communities screened	47		41		50		29		35		55		43		37		41		31		45	
Observed prevalence (screened communities only) ‡	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion
≥20%	10	21%	4	10%	6	12%	1	3%	3	9%	12	22%	8	19%	3	8%	3	7%	3	10%	4	9%
≥10% to <20%	4	9%	2	5%	9	18%	3	10%	13	37%	10	18%	13	30%	8	22%	6	15%	4	13%	5	11%
≥5% to <10%	2	4%	3	7%	7	14%	2	7%	4	11%	4	7%	6	14%	8	22%	7	17%	2	6%	3	7%
>0% to <5%	6	13%	7	17%	6	12%	5	17%	3	9%	6	11%	2	5%	4	11%	4	10%	1	3%	6	13%
0%	25	53%	25	61%	22	44%	18	62%	12	34%	23	42%	14	33%	14	38%	21	51%	21	68%	27	60%

* As defined annually by each jurisdiction.

† As per CDNA Guidelines. Includes communities that were not screened due to logistical or demographic reasons (i.e., no children in the 5–9-year age group).

‡ If more than one screening episode occurs during the calendar year, data from the first screen is used.

Table 2.1 Treatment strategies by region, Northern Territory, 2024

Number of communities	Alice Springs Remote	Barkly	Darwin Rural	Katherine	Total
Required treatment for trachoma	11	1	1	5	18
Treated for trachoma	11	1	1	5	18
Screened and treated	11	1	1	5	18
Received treatment only	0	0	0	0	0
Received 6-monthly treatment	0	0	0	0	0
Did not require treatment	15	7	1	4	27
Treated active trachoma and household contacts	8	1	1	2	12
Community-wide treatment	3	0	0	3	6
Not treated according to CDNA Guidelines	0	0	0	0	0

Table 2.2 Antibiotic distribution and coverage by age and region, Northern Territory, 2024

	Alice Springs Remote					Barkly					Darwin Rural					Katherine					Total				
Age group (years)	0–4	5–9	10–14	15+	All	0–4	5–9	10–14	15+	All	0–4	5–9	10–14	15+	All	0–4	5–9	10–14	15+	All	0–4	5–9	10–14	15+	All
Requiring treatment for active trachoma	1	27	2		30	0	1	1		2	0	1	0		1	0	27	0		27	1	56	3		60
Received treatment for active trachoma	1	24	2		27	0	1	1		2	0	1	0		1	0	27	0		27	1	53	3		57
<i>Received treatment for active trachoma (%)</i>	<i>100</i>	<i>89</i>	<i>100</i>		<i>90</i>	<i>N/A</i>	<i>100</i>	<i>100</i>		<i>100</i>	<i>N/A</i>	<i>100</i>	<i>N/A</i>		<i>100</i>	<i>N/A</i>	<i>100</i>	<i>N/A</i>		<i>100</i>	<i>100</i>	<i>95</i>	<i>100</i>		<i>95</i>
Estimated community members* requiring treatment	88	136	140	811	1175	0	2	3	8	13	1	0	1	4	6	186	162	207	1189	1744	275	300	351	2012	2938
Number of community members who received treatment	64	89	84	499	736	0	2	3	8	13	1	0	1	4	6	72	115	82	501	770	137	206	170	1012	1525
<i>Estimated community members who received treatment (%)</i>	<i>73</i>	<i>65</i>	<i>60</i>	<i>62</i>	<i>63</i>	<i>N/A</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>N/A</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>39</i>	<i>71</i>	<i>40</i>	<i>42</i>	<i>44</i>	<i>50</i>	<i>69</i>	<i>48</i>	<i>50</i>	<i>52</i>
Number of community members that refused treatment	5	7	6	34	52	0	0	0	0	0	0	0	0	0	0	6	0	6	52	64	11	7	12	86	116
Total number of doses of azithromycin delivered	65	113	86	499	763	0	3	4	8	15	1	1	1	4	7	72	142	82	501	797	138	259	173	1012	1582
<i>Estimated overall treatment coverage (%)</i>	<i>73</i>	<i>69</i>	<i>61</i>	<i>62</i>	<i>63</i>	<i>N/A</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>39</i>	<i>75</i>	<i>40</i>	<i>42</i>	<i>45</i>	<i>50</i>	<i>73</i>	<i>49</i>	<i>50</i>	<i>53</i>

* Estimated as per CDNA Guidelines

Table 2.6 Trachomatous trichiasis (TT) screening coverage, TT screened proportion, and surgery among Indigenous persons by region, Northern Territory, 2024

	Alice Springs Remote		Barkly		Darwin Rural		East Arnhem		Katherine		Total		
Number of communities screened for TT	27		9		15		17		21		89		
Age group (years)	15–39	40+	15–39	40+	15–39	40+	15–39	40+	15–39	40+	15–39	40+	15+
Adults examined*	2140	2342	301	353	2541	2231	423	473	2315	2157	7720	7556	15276
With TT †	0	1	0	2	0	0	0	1	0	1	0	5	5
With TT (%)	0.00	0.04	0.00	0.57	0.00	0.00	0.00	0.21	0.00	0.05	0.00	0.07	0.03
Surgery in past 12 months‡	0	2	0	0	0	0	0	0	0	0	0	2	2

* This number may not account for all adults who may be examined in routine adult health checks and may also include multiple screenings per patient. Screening is linked to trachoma endemic regions and does not consider changing endemic regions over time and transiency between regions.

† Defined as cases ‘previously unknown to the health system’.

‡ Surgery may include cases identified in previous years.

Table 2.3 Health promotion activities by region, Northern Territory, 2024

	Alice Springs Remote	Barkly	Darwin Rural	Katherine	Total
Number of communities that reported health promotion activities	26	8	2	1	37
Total number of programs reported	74	21	9	3	107
Methods of health promotion					
One-on-one discussion	57	14	7	2	80
Presentation to group	15	4	1	0	20
Interactive group session	36	14	2	1	53
Social marketing	5	1	0	0	6
Print material/mass media	10	4	0	0	14
Sporting/community events	7	0	1	0	8
Other	9	2	2	0	13
Target audience					
Health professionals/staff	19	6	2	1	28
Children	38	13	2	1	54
Youth	14	0	0	0	14
Teachers/childcare/ preschool staff	29	11	3	1	44
Caregivers/parents	30	5	5	2	42
Community members	40	10	4	1	55
Community educators/ health promoters	8	3	0	0	11
Interagency members	9	2	2	0	13
Frequency of health promotion activities					
Once	61	20	9	3	93
Occasional*	13	1	0	0	14
Regular†	0	0	0	0	0
Ongoing/routine	0	0	0	0	0

* 2–4 times per year

† 5–12 times per year

Queensland results

Health promotion

Queensland (Qld) had no communities considered at risk of trachoma in 2024, however hygiene health promotion education and activities continued in one large community historically at risk to sustain achievements (Table 3.1). The Qld Health Trachoma Team, in collaboration with local council and school staff, delivered health promotion sessions to all levels K-10 at the community's school three times throughout the school year. A wide range of audio and visual resources are used to promote *Milpa's Six Steps to Stop Germs* messages, as well as practical hand washing and tooth brushing demonstrations. Hygiene packs, including face washer, soap, toothbrush and toothpaste (age specific), tissues, and hairbrush, were also distributed to reinforce the six steps. In 2024, the Trachoma Team involved the Dental Health Team in program delivery to support a holistic focus in health messaging. For older children, sessions were delivered in partnership with the Skin Health Team, which has created a pathway to enable regular ongoing skin health assessments to be undertaken at the school. These models of co-program delivery will be further expanded in 2025.

The Qld Health Trachoma Team also provided interactive health promotion education during the annual health fair and at the Rheumatic Heart Disease Health Summit in conjunction with the community health team.

Three soap distributions were organised in 2024, equating to approximately 5,000 bars of soap. In addition, 30 large household cleaning kits were purchased which included mops, buckets, hoses, and household cleaning supplies. Distribution of these hygiene resources was arranged via service providers, healthcare, council, and non-government organisations.

Figures and Tables – Queensland

Table 3.1 Health promotion activities, Queensland, 2024

Queensland	
Number of communities that reported health promotion activities	1
Total number of programs reported	3
Method of health promotion activities	
One-on-one discussion	0
Presentation to group	0
Interactive group session	1
Social marketing	0
Print material/mass media	0
Sporting/community events	1
Other	1
Target audience	
Health professional/staff	0
Children	1
Youth	1
Teachers/childcare/preschool staff	1
Caregivers/parents	0
Community members	1
Community educators/health promoters	0
Interagency members	0
Frequency of health promotion activities	
Once	0
Occasional*	3
Regular†	0
Ongoing/routine	0

*2–4 times per year.

† 5–12 times per year.

South Australia results

Trachoma program coverage

In 2024, SA identified 16 communities in three regions as requiring screening for trachoma (Figure 4.2, Table 4.1). Of these 16 communities, 11 were considered currently at risk of trachoma. The other five communities were previously removed from the at-risk register however due to population linkages to current at-risk communities were also screened as part evidence confirmation for final-year dossier validation surveillance.

15 of the 16 communities (94%) that required screening were screened for trachoma in 2024 (Figure 4.3, Table 4.1).

Trachoma screening coverage

Within these 15 communities, 91% of children (446/490) were screened for trachoma. Screening coverage ranged from 86% in the APY Lands region to 99% in the Eyre and Western region (Table 4.2).

Facial cleanliness

Facial cleanliness was assessed in all communities that were screened (data not shown).

The total proportion of clean faces among children aged 5–9 years across screened communities was 89% (390/436). Proportions ranged from 82% in the APY Lands region to 99% in the Far North region (Figure 4.4, Table 4.2).

Trachoma prevalence

No trachoma was reported in children aged 5–9 years among communities screened in 2024. The overall prevalence of trachoma remains at 0.0% in SA (Figure 4.5c, Table 4.2).

Treatment delivery and coverage

No treatment for trachoma was required in any of the 15 communities screened (Table 4.4).

Trachomatous Trichiasis (TT)

Screening for TT was undertaken in 13 communities, with 1,054 persons aged 15 years and over screened (Table 4.5).

Three cases of TT were detected among persons screened in 2024, a rate of 0.3% (Table 4.5).

No persons were identified as having received surgery to correct TT in the past 12 months (Table 4.5).

Health promotion and environmental health activities

The SA Government in collaboration with Aboriginal partners and other key stakeholders has adopted a comprehensive approach to address the facial cleanliness and environmental improvement components of the SAFE strategy across three regions: Eyre and Far North, Flinders and Upper North, and the APY Lands. This approach aims to:

Implement initiatives to improve environmental health sustainably.

Enhance health literacy among community members.

Encourage behaviours that reduce the risk of trachoma and other infectious diseases.

Ensure quicker access to home repairs and maintenance services.

In 2024, 23^{iv} currently and formerly at-risk communities across the jurisdiction received facial cleanliness health promotion activities and environmental health improvement measures under the trachoma funding initiative. A standout achievement for the year was the Flinders and Upper North Trachoma Team honoured with the "Our People, Our Pride: Excellence in Aboriginal Health and Wellbeing" award.

Initiatives to improve facial cleanliness in 2024 included:

Health promotion and education activities (including visits from Milpa the Goanna, the mascot for eye health) were delivered to students and staff at twenty schools located in the three regions. Face-washing routines have been embedded in regular school practice in Aboriginal communities.

Trachoma prevention messages were posted regularly during 2024 on social media across rural SA.

Key partners donated cleaning products, clothing, blankets, sanitisers, towels, and soap, which were delivered across Aboriginal communities. Additionally, new washing machines and dryers have been purchased for community laundry facilities.

Nganampa Health Council continues to support the provision of handwashing facilities in community locations and as part of key community events.

Environmental health staff continue to conduct home assessments in at-risk communities to address any hardware concerns that impede healthy living practices, such as plumbing, dust control, waste management, and pest control. In 2024:

103 dwellings received health hardware assessments and associated repairs.

Advocacy and assistance were provided to 58 households for the reporting of more complex repairs and maintenance needs to the relevant SA Government agency.

401 householders participated in environmental health education activities.

In addition, the SA government is advancing its Water Quality Initiative program to tackle drinking water quality issues in remote communities. This program involves investment in testing, funding, and governance structures to support the implementation of sustainable water treatment technologies.

^{iv} This figure is higher than Table 4.6, which summarises facial cleanliness-specific activities.

Figures and Tables – South Australia

Figure 4.2 Overall trachoma prevalence in children aged 5–9 years by region, South Australia, 2024

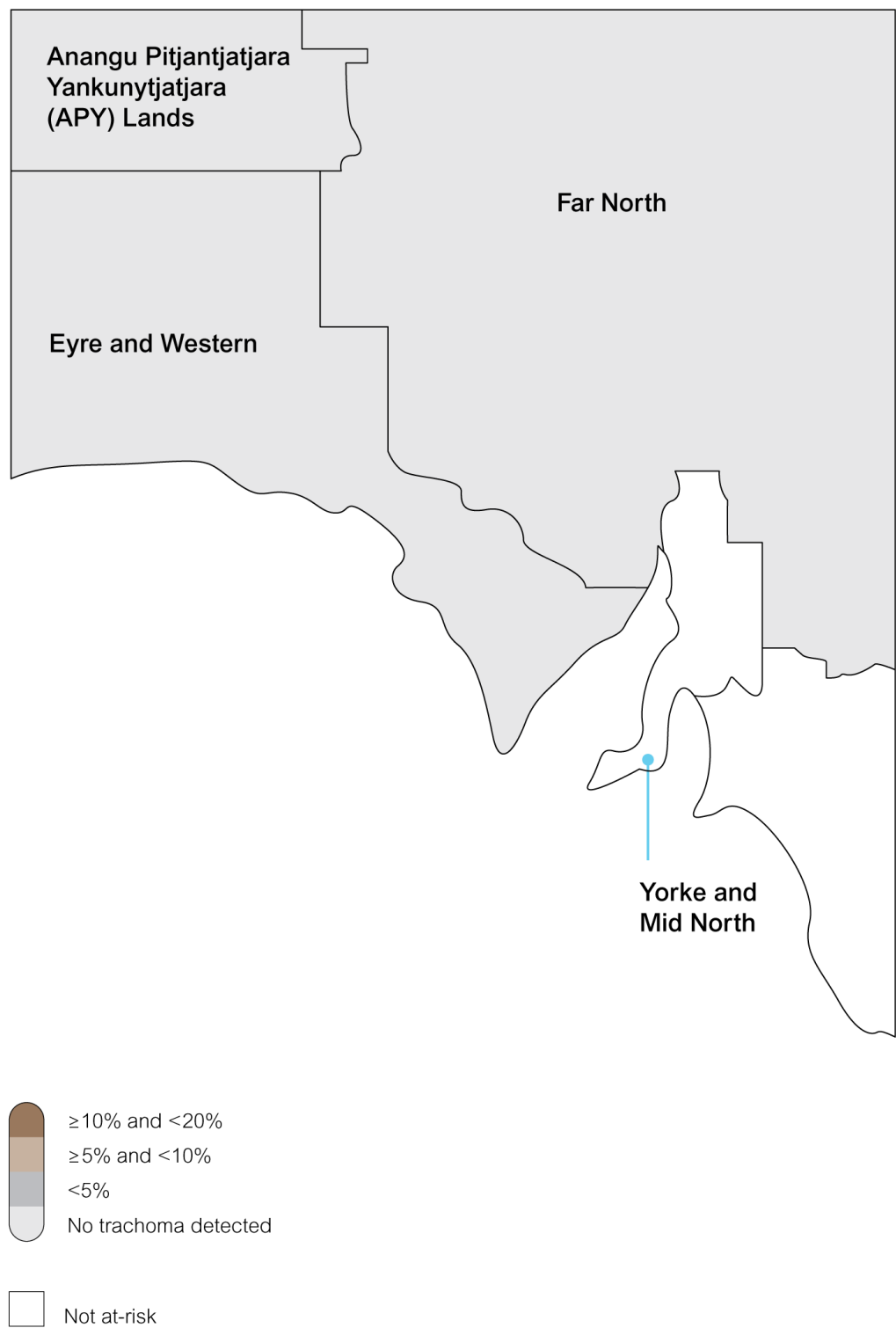
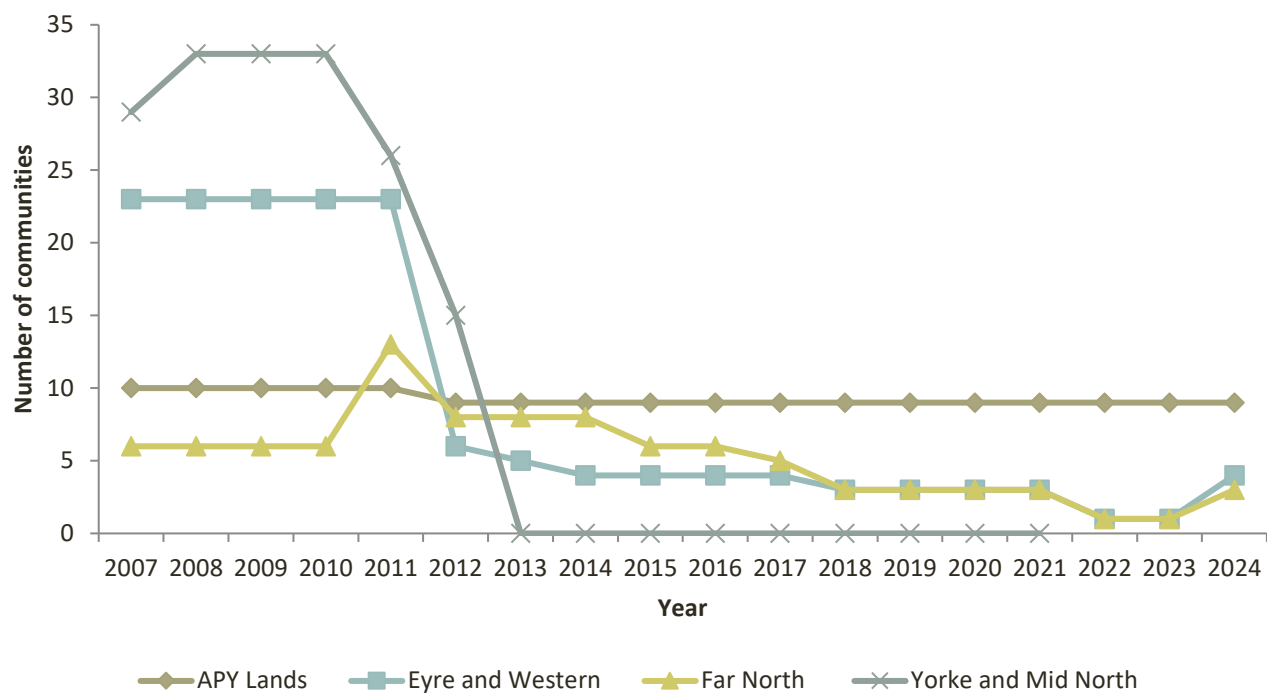


Figure 4.2 Number of at-risk communities* by region, South Australia, 2007–2024



* 2024 data points include communities identified for evidence confirmation screening for final-year dossier validation surveillance (refer to Findings and interpretation).

Figure 4.3 Number of at-risk communities according to trachoma control strategy implemented by region, South Australia, 2024

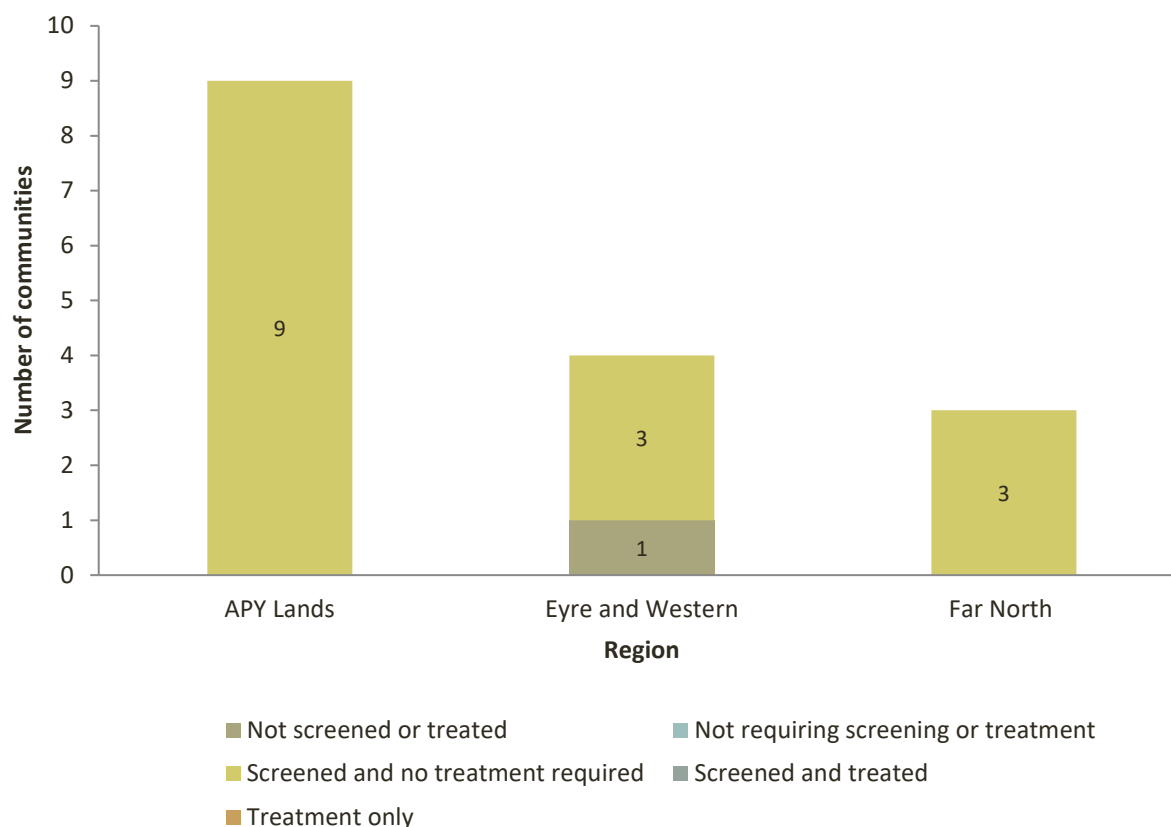


Figure 4.4 Proportion of screened children aged 5–9 years who had a clean face by region, South Australia, 2007–2024

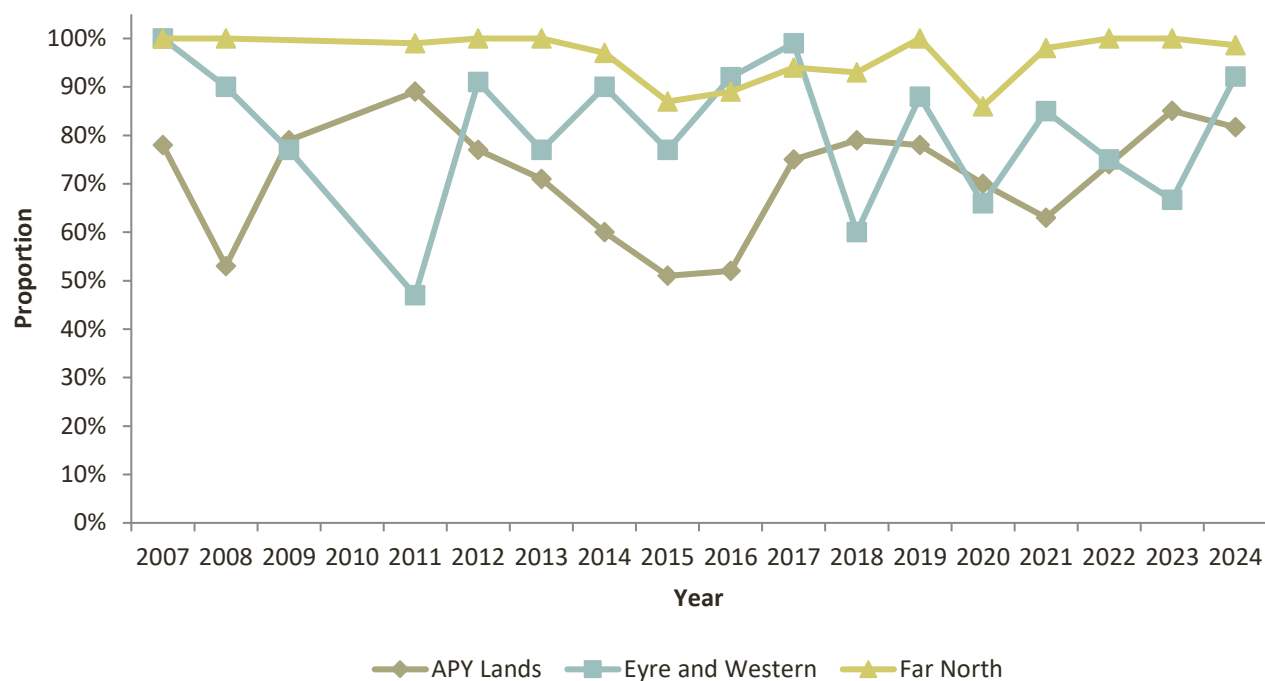
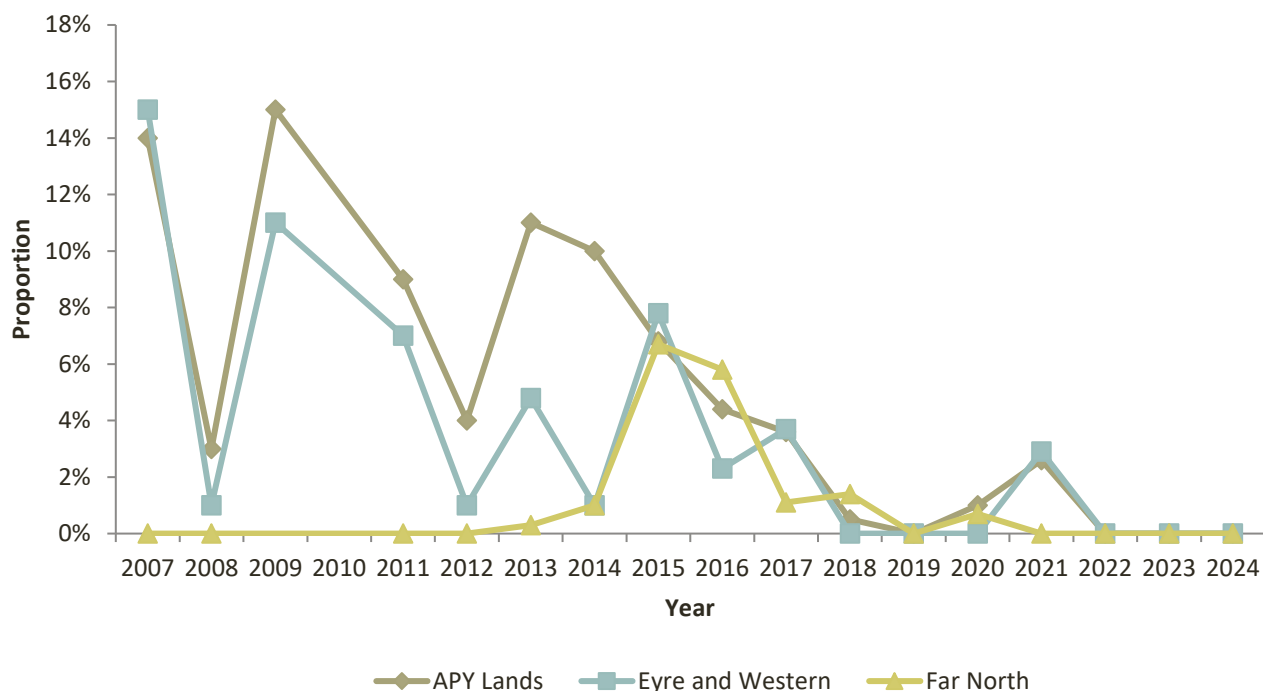
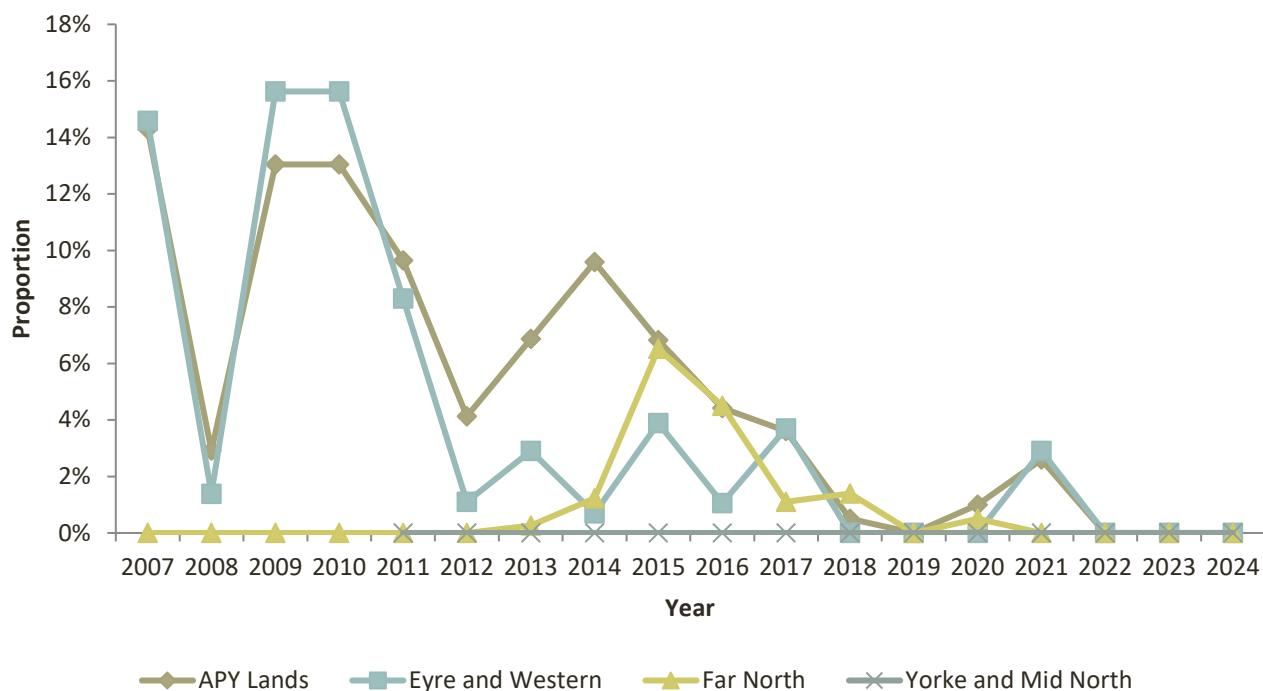


Figure 4.5a Observed prevalence of clinical findings consistent with trachomatous inflammation—follicular/intense* among screened children aged 5–9 years by region, South Australia, 2007–2024



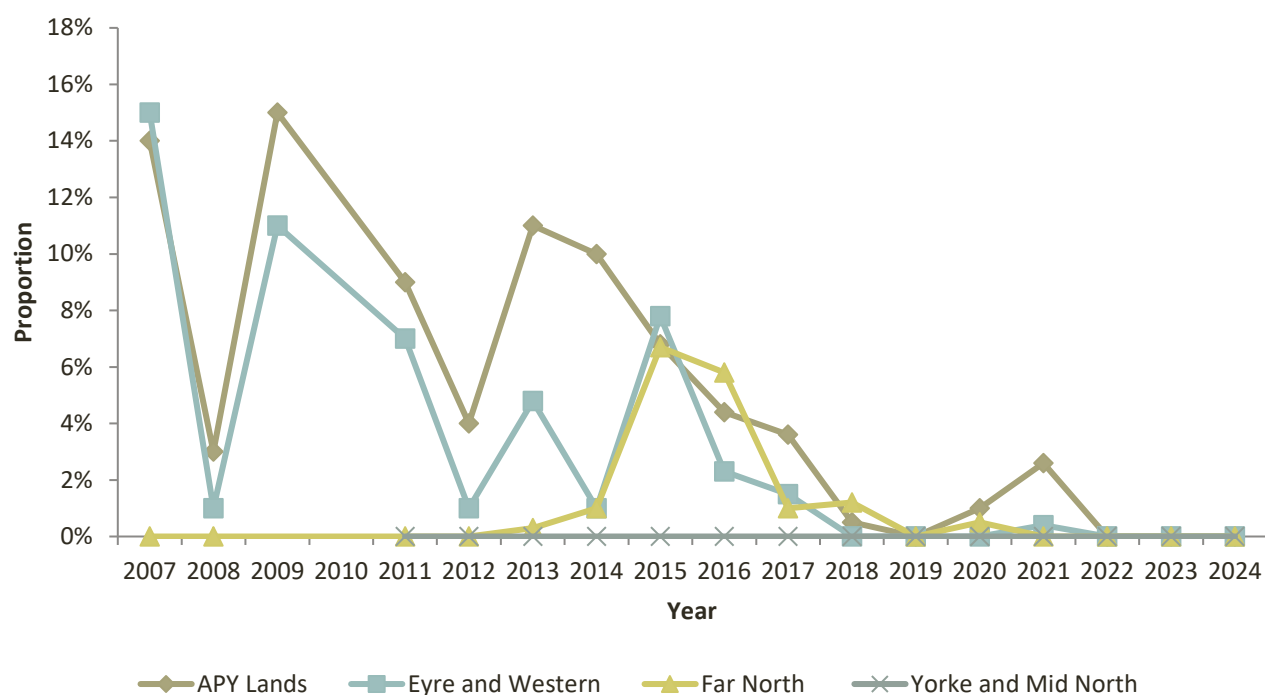
*According to WHO simplified trachoma grading criteria²

Figure 4.5b Estimated prevalence of trachoma among children aged 5–9 years in all at-risk communities* by region, South Australia, 2007–2024



* Most recent estimates carried forward in at-risk communities that did not screen in 2024.

Figure 4.5c Overall prevalence of trachoma among children aged 5–9 years in all communities* by region, South Australia, 2007–2024



* Calculated carrying forward most recent data in all communities considered at risk of trachoma at any point since 2007.

Figure 4.6 Number of screened at-risk communities according to the level of observed trachoma prevalence in children aged 5–9 years by region, South Australia, 2024

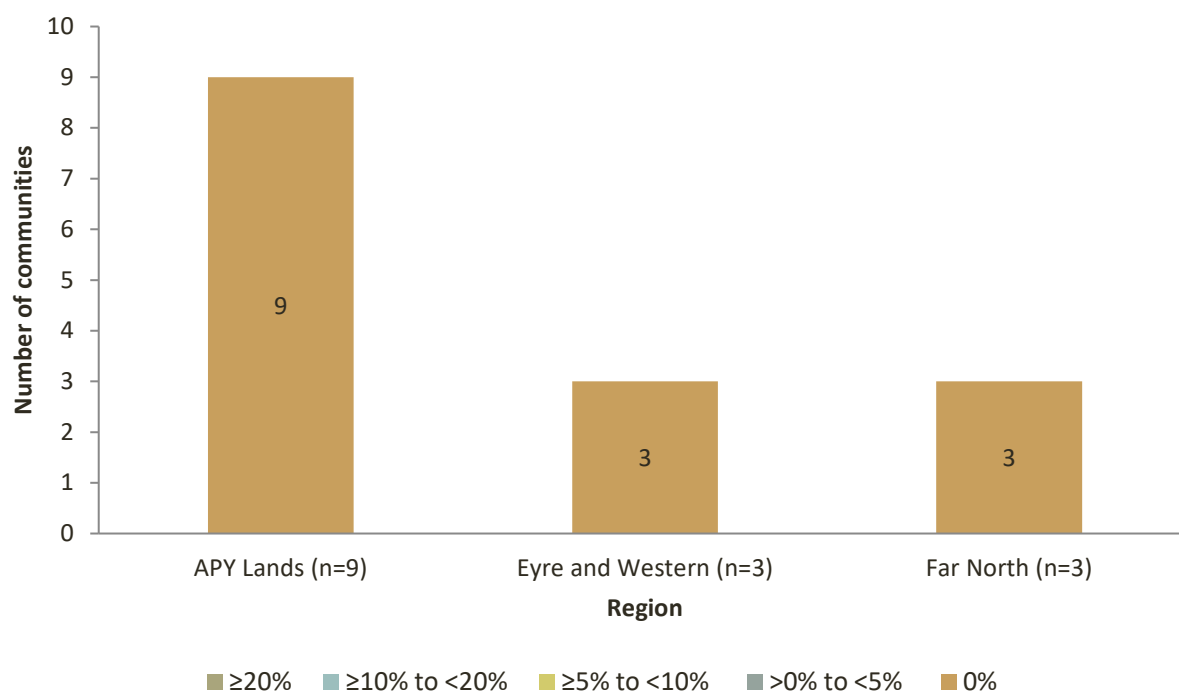


Figure 4.7 Number of doses of azithromycin administered for the treatment of trachoma by region, South Australia, 2007–2024

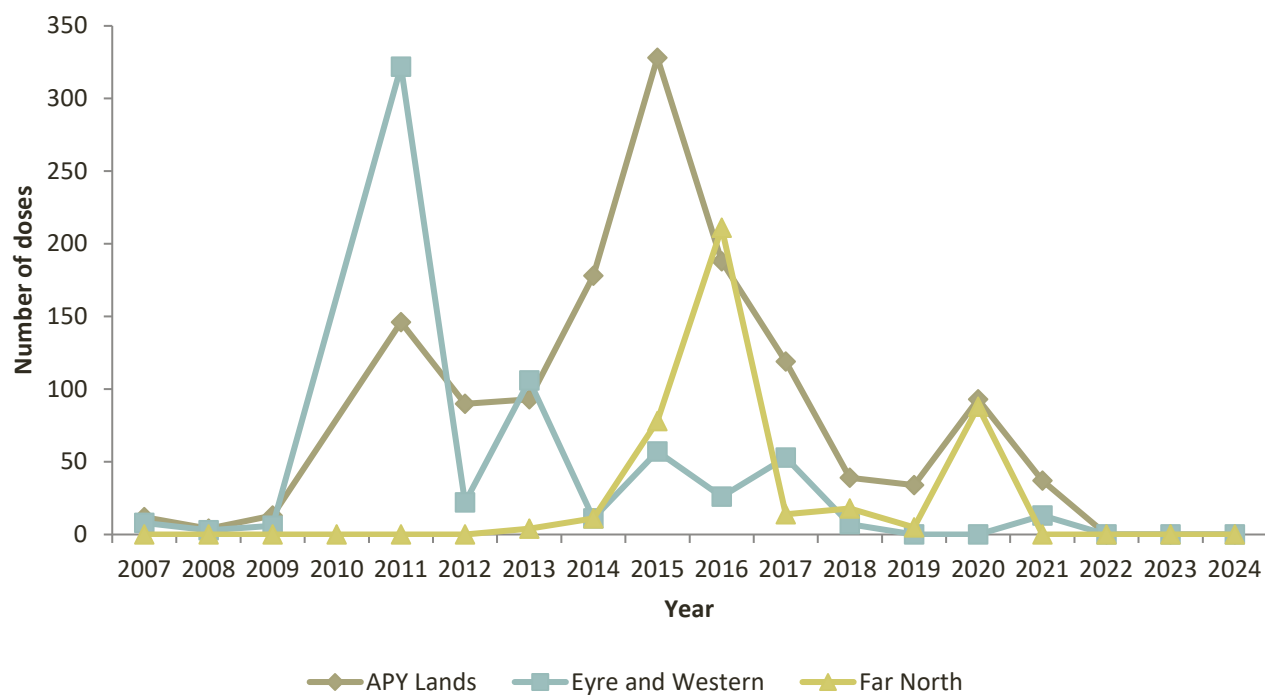


Table 4.4 Trachoma control delivery in at-risk communities by region, South Australia, 2024

Number of communities	APY Lands	Eyre and Western	Far North	Total
At risk (A)*	9	4	3	16
Requiring screening for trachoma (B)	9	4	3	16
Screened for trachoma (C)	9	3	3	15
Requiring treatment without screening† (D)	0	0	0	0
Received treatment without screening (E)	0	0	0	0
Screened and/or treated for trachoma (F=C+E)	9	3	3	15
Requiring neither screening nor treatment for trachoma (G=A-B-D)	0	0	0	0

* As defined by each jurisdiction, including communities identified for evidence confirmation screening for final-year dossier validation surveillance (refer to Findings and interpretation).

† As per CDNA Guidelines

Table 4.5 Trachoma screening coverage, trachoma prevalence, and clean face proportion in children aged 5–9 years by region, South Australia, 2024

	APY Lands	Eyre and Western	Far North	Total
Number of communities screened	9	3	3	15
Estimated number* of Aboriginal children in communities	236	100	154	490
Children examined for clean face	202	89	145	436
Children with clean face	165	82	143	390
Clean face (%)	82	92	99	89
Children screened for trachoma	202	99	145	446
Trachoma screening coverage (%)	86	99	94	91
Children with active trachoma	0	0	0	0
Observed prevalence of active trachoma† (%)	0.0	0.0	0.0	0.0
Estimated prevalence of active trachoma‡ (%)	0.0	0.0	0.0	0.0
Overall prevalence of active trachoma (%)	0.0	0.0	0.0	0.0

* Jurisdictional estimate.

† Communities that were screened for trachoma in 2024.

‡ Prevalence rate calculations are described in the Methodology section.

Table 4.6 Number and proportion of at-risk communities according to the level of observed trachoma prevalence in children aged 5–9 years, South Australia, 2014–2024

	2014		2015		2016		2017		2018		2019		2020		2021		2022		2023		2024	
Communities at-risk*	21		19		19		18		15		15		15		15		11		11		16	
At-risk communities not screened or treated without screening†	0		0		0		0		0		0		0		0		0		0		1	
At-risk communities screened	21		19		19		18		15		15		15		15		11		11		15	
Observed prevalence (screened communities only) ‡	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion
≥20%	1	5%	2	11%	1	5%	1	5%	1	7%	0	0%	0	0%	1	7%	0	0%	0	0%	0	0%
≥10% to <20%	9	43%	3	16%	1	5%	1	6%	0	0%	0	0%	1	7%	0	0%	0	0%	0	0%	0	0%
≥5% to <10%	0	0%	9	47%	2	11%	3	17%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
>0% to <5%	1	5%	1	5%	1	58%	1	56%	1	66%	0	0%	9	60%	9	60%	0	0%	0	0%	0	0%
0%	1	48%	4	21%	4	21%	3	17%	4	27%	1	100%	5	33%	5	33%	1	100%	1	100%	1	100%

* As defined annually by each jurisdiction.

† As per CDNA Guidelines. Includes communities that were not screened due to logistical or demographic reasons (i.e., no children in the 5–9-year age group).

‡ If more than one screening episode occurs during the calendar year, data from the first screen is used.

Table 4.7 Treatment strategies by region, South Australia, 2024

Number of communities	APY Lands	Eyre and Western	Far North	Total
Required treatment for trachoma	0	0	0	0
Treated for trachoma	0	0	0	0
Screened and treated	0	0	0	0
Received treatment only	0	0	0	0
Received 6-monthly treatment	0	0	0	0
Did not require treatment	9	3	3	15
Treated active trachoma and household contacts	0	0	0	0
Community-wide treatment	0	0	0	0
Not treated according to CDNA Guidelines	0	0	0	0

Table 4.5 Trachomatous trichiasis (TT) screening coverage, TT screened proportion, and surgery among Indigenous persons by region, South Australia, 2024

	APY Lands		Eyre and Western		Far North		Total		
Number of communities screened for TT	9		2		2		13		
Age group (years)	15–39	40+	15–39	40+	15–39	40+	15–39	40+	15+
Adults examined*	413	406	7	111	18	99	438	616	1054
With TT †	0	2	0	1	0	0	0	3	3
With TT (%)	0.00	0.49	0.00	0.90	0.00	0.00	0.00	0.49	0.28
Surgery in past 12 months‡	0	0	0	0	0	0	0	0	0

* This number may not account for all adults who may be examined in routine adult health checks and may also include multiple screenings per patient. Screening is linked to trachoma endemic regions and does not consider changing endemic regions over time and transiency between regions.

† Defined as cases ‘previously unknown to the health system’.

‡ Surgery may include cases identified in previous years.

Table 4.6 Health promotion activities by region, South Australia, 2024

	APY Lands	Eyre and Western	Far North	Total
Number of communities that reported health promotion activities	9	3	6	18
Total number of programs reported	4	6	12	22
Methods of health promotion				
One-on-one discussion	4	2	1	7
Presentation to group	2	4	7	13
Interactive group session	0	1	2	3
Social marketing	1	1	1	3
Print material/mass media	2	0	0	2
Sporting/community events	3	0	3	6
Other	2	1	2	5
Target audience				
Health professionals/staff	1	2	4	7
Children	3	3	6	12
Youth	1	3	6	10
Teachers/childcare/preschool staff	3	3	6	12
Caregivers/parents	3	3	5	11
Community members	1	0	3	4
Community educators/health promoters	2	0	0	2
Interagency members	0	0	0	0
Frequency of health promotion activities				
Once	0	0	3	3
Occasional *	0	5	8	13
Regular†	3	0	0	3
Ongoing/routine	1	1	1	3

* 2–4 times per year.

† 5–12 times per year.

Western Australia results

Trachoma program coverage

In 2024, WA identified 33 communities in 4 regions as being at risk of trachoma (Figure 5.2, Table 5.1).

26 at-risk communities required trachoma screening in 2024 (79%) and all of these communities received screening (Figure 5.3, Table 5.1).

Trachoma screening coverage

The total proportion of children aged 5–9 years screened for trachoma across all at-risk communities in WA was 92% (295/320). Screening coverage ranged from 86% in the Kimberley region to 100% in the Midwest region (Table 5.2).

Facial cleanliness

Facial cleanliness among children aged 5–9 years was assessed in all communities that were screened (data not shown).

The total proportion of clean faces across all screened communities in WA was 76% (225/296). Proportions ranged from 44% in the Pilbara region to 90% in the Kimberley region (Figure 5.4, Table 5.2).

Trachoma prevalence

The observed prevalence of trachoma in children aged 5–9 years in screened communities was 4.1% (12/295). Observed prevalence was 9.3% in the Pilbara region and 6.5% in the Goldfields region. No trachoma was reported in the Kimberley and Midwest regions (Figure 5.5a, Table 5.2).

The overall prevalence of trachoma in children aged 5–9 years was 1.3%. Overall prevalence ranged from 0.0% in the Midwest region to 3.2% in the Pilbara region (Figure 5.5c, Table 5.2).

No trachoma was reported in 19/26 (73%) of the screened at-risk communities (Figure 5.6, Table 5.3).

Endemic trachoma (observed prevalence $\geq 5\%$) was reported in 6/26 (23%) of the screened at-risk communities (Figure 5.6, Table 5.3).

Hyperendemic trachoma (observed prevalence $\geq 20\%$) was reported in one of the screened at-risk communities (Figure 5.6, Table 5.3).

Treatment delivery and coverage

Trachoma treatment strategies were required in seven communities. All of these communities received treatment, which was provided to active trachoma cases and households (Table 5.4).

Total treatment coverage for trachoma cases and contacts in all regions requiring treatment was 87% with 92 doses of azithromycin delivered. Total treatment coverage was 80% (53 doses administered) in the Goldfields and 98% (39 doses administered) in the Pilbara region (Figure 5.7, Table 5.5).

Trachomatous Trichiasis (TT)

Overall, 2313 persons aged 15 years and older were reported to be screened for TT in 2024. No new cases of TT were identified (Table 5.6).

Surgery for TT was reported to be undertaken for four people in 2024 (Table 5.6).

Health promotion

Health promotion activities in WA continue to be a collaborative effort coordinated by WACHS Central Office with the Public Health staff in the four trachoma endemic regions (Goldfields, Midwest, Pilbara, and Kimberley), WA Environmental Health Directorate, Soap Aid Ltd, Aboriginal Health Council of Western Australia, Public Health Advocacy Institute, and IEHU. Collaboration with other environmental health-related disease programs such as rheumatic heart disease, dental, and skin health have also continued.

School, home, and community-based health promotion sessions were undertaken in 48 communities designated at risk of trachoma or trachoma resurgence (Table 5.7). Health hygiene activities were tailored to be appropriate to the intended audience. Regional teams used a variety of resources to promote engagement including soap making activities, stickers, children's story books, UV light to assess hand washing techniques, and personal hygiene packs.

WACHS Population Health staff continue to provide support, resources, and training for health, education, and environmental health services within the Pilbara, Goldfields, Kimberley, and Midwest regions to encourage these services to also promote positive hygiene messaging and practice in relevant communities. WACHS contract additional child and school health services to increase access and improve health outcomes for rural and remote populations. Contracts with these services within the four trachoma endemic regions include deliverables related to health hygiene programs.

The health promotion program also aims to overcome barriers to good hygiene in remote communities. The provision of free soap is available to Aboriginal households and in public facilities in communities that are at risk of trachoma or at risk of trachoma resurgence. Soap is stored in each region with external partner organisations who assist with distribution during clinical visits, healthy home assessments, health promotion events, and at the request of other services. Over 103,680 bars of soap were provided across the regions in 2024.

Environmental Health

In providing and coordinating the 'E' component of the SAFE strategy, WA Environmental Health Directorate works with and collaborates with Public Health staff, Public Health Advocacy Institute, and its local/regional contracted Aboriginal Environmental Health service providers on initiatives to support communities with environmental health improvements. These initiatives continued in 2024 and included community-wide intensive multi-agency as well as dedicated Aboriginal Environmental Health service activities. A total of 381 Environmental Health Practitioner visits were recorded from 1 January to 31 December 2024.

A cornerstone of WA's environmental health improvement approach is the 'healthy homes assessment'. These have provided positive outcomes by identifying health hardware faults and fixing them on the spot (same day) when possible. The environmental health workforce undertook 1,268 healthy homes assessments in 28 communities across the trachoma endemic regions in 2024. Referrals were submitted to external agencies (e.g., housing providers) for required maintenance that was outside the scope of the environmental health practitioners, and advice was provided to community members on remediation measures. Other complementary environmental health related services delivered included domestic and community hard waste removal, distribution of home health hardware resources, and pest control.

Figures and Tables – Western Australia

Figure 5.1 Overall trachoma prevalence in children aged 5–9 years by region, Western Australia, 2024



Figure 5.2 Number of at-risk communities by region, Western Australia, 2007–2024

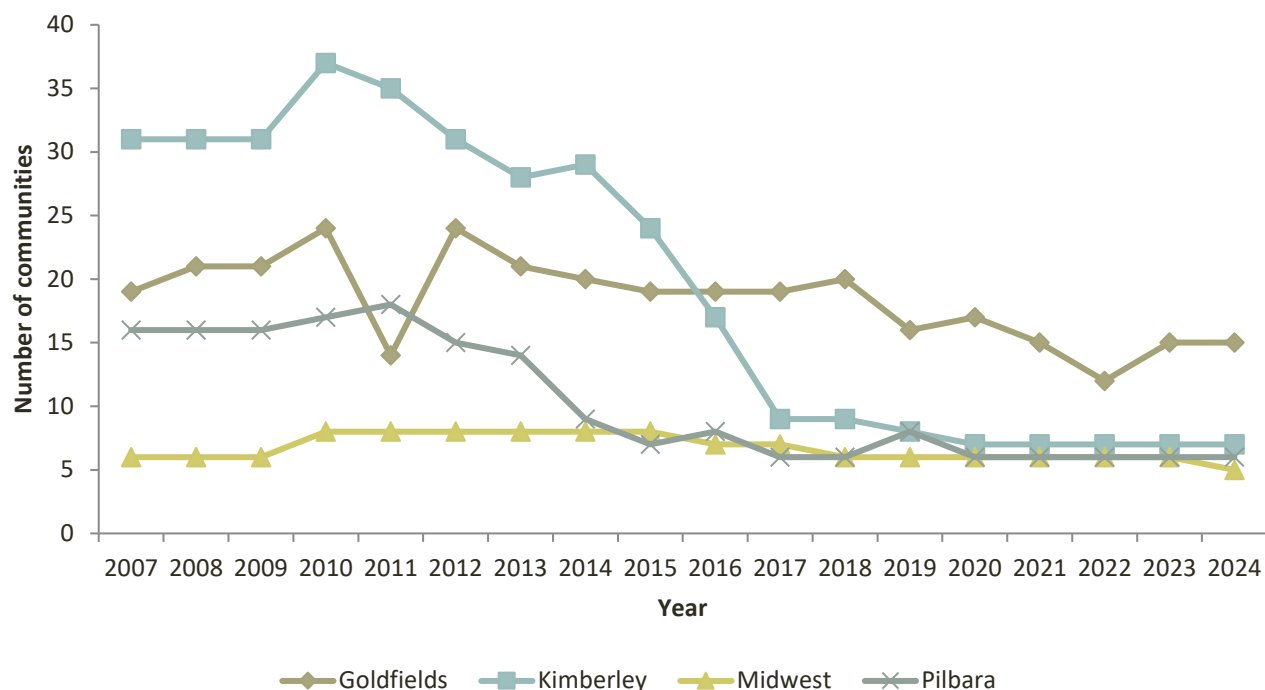


Figure 5.3 Number of at-risk communities according to trachoma control strategy implemented by region, Western Australia, 2024

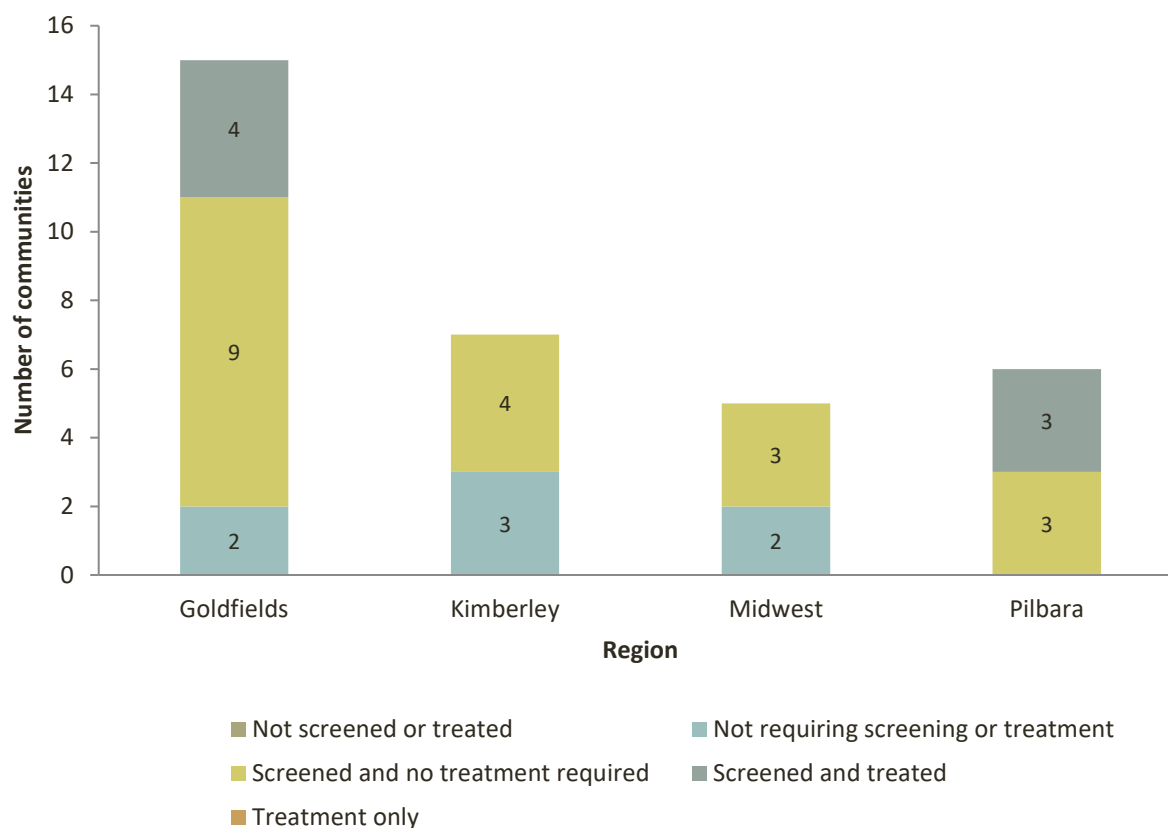


Figure 5.4 Proportion of screened children aged 5–9 years who had a clean face by region, Western Australia, 2007–2024

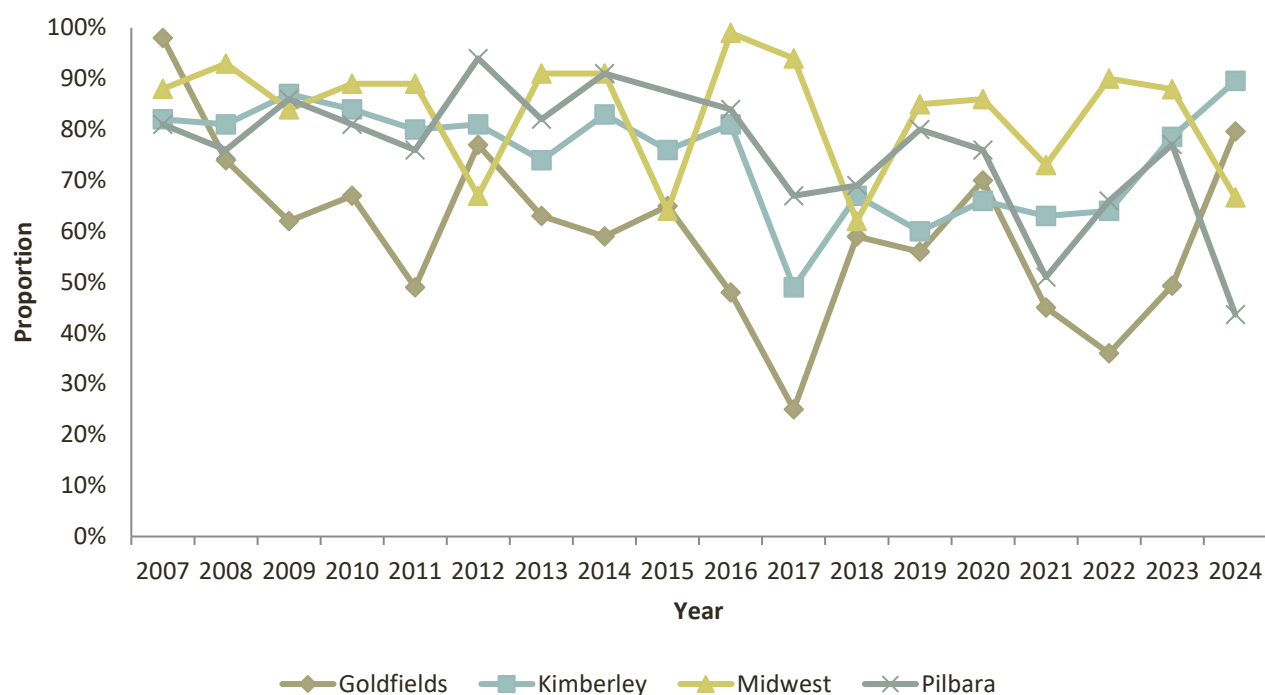
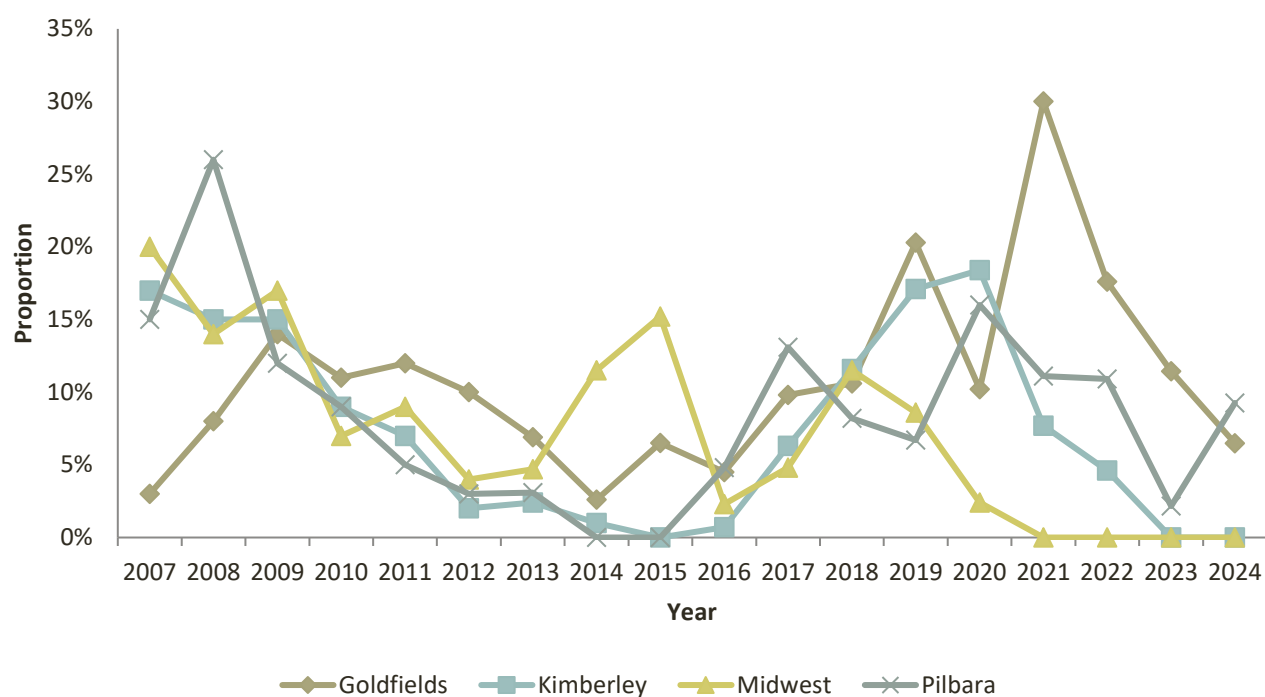
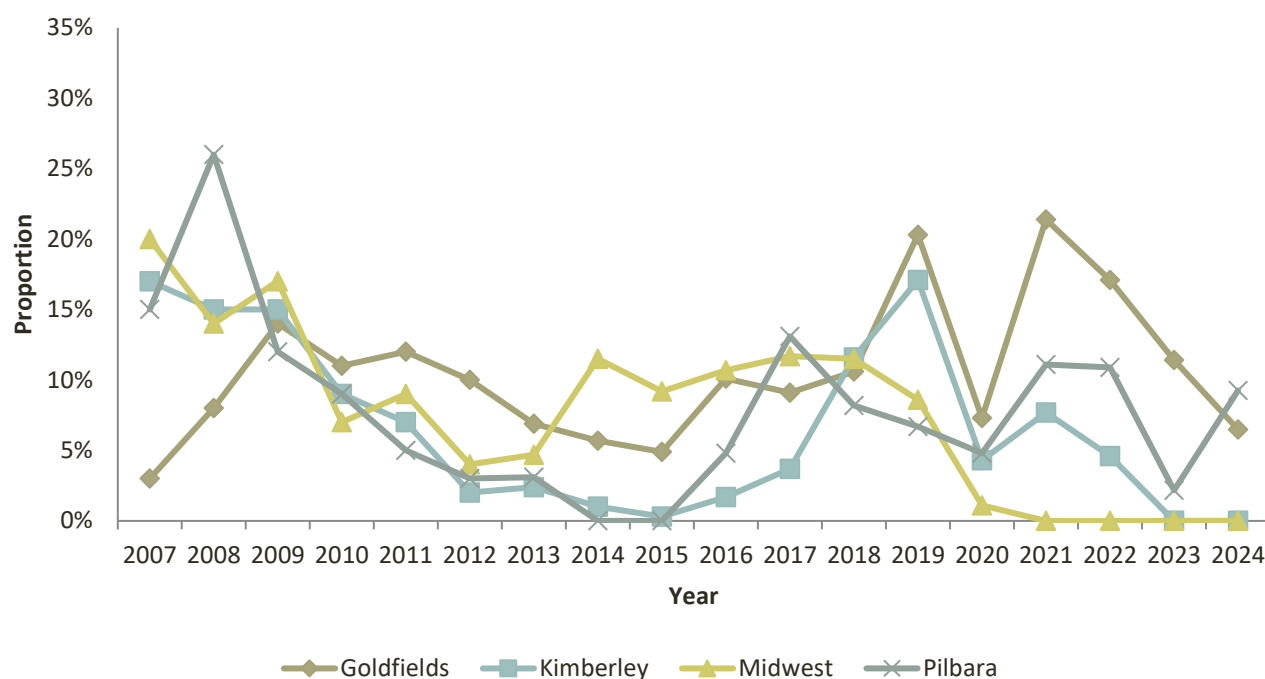


Figure 5.5a Observed prevalence of clinical findings consistent with trachomatous inflammation—follicular/intense* among screened children aged 5–9 years by region, Western Australia, 2007–2024



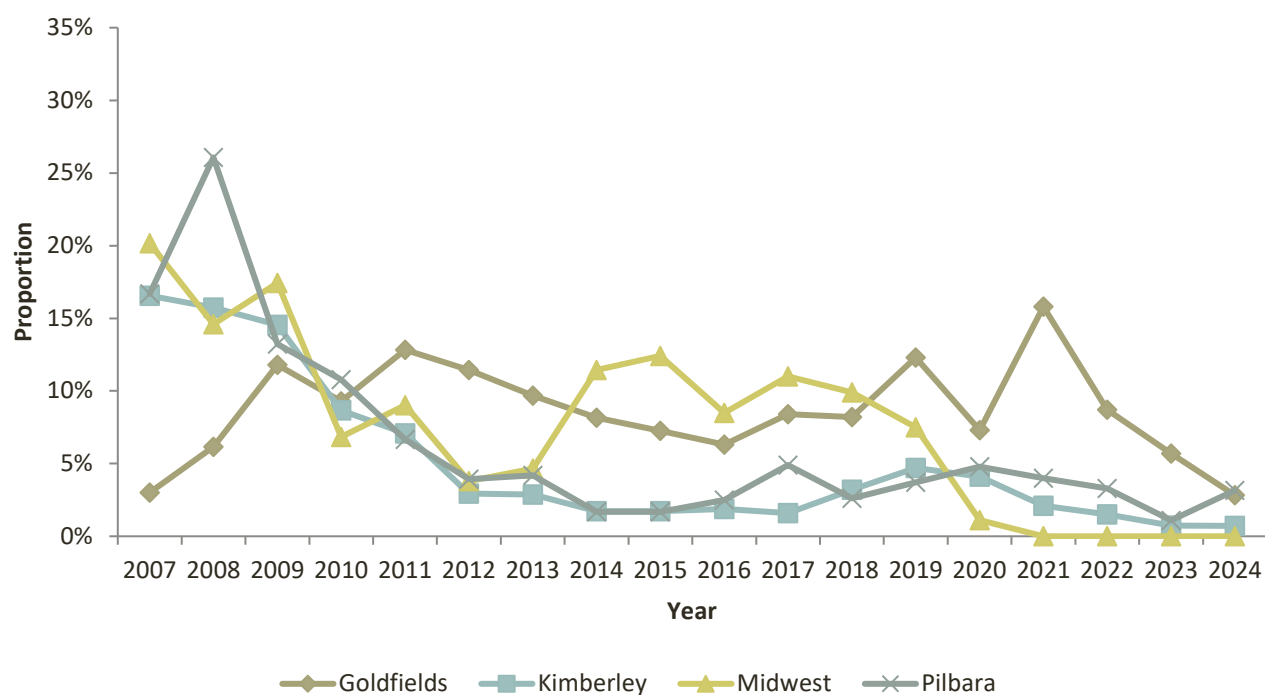
*According to WHO simplified trachoma grading criteria²

Figure 5.5b Estimated prevalence of trachoma among children aged 5–9 years in all at-risk communities* by region, Western Australia, 2007–2024



* Most recent estimates carried forward in at-risk communities that did not screen in 2024.

Figure 5.5c Overall prevalence of trachoma among children aged 5–9 years in all communities* by region, Western Australia, 2007–2024



* Calculated carrying forward most recent data in all communities considered at risk of trachoma at any point since 2007.

Figure 5.6 Number of screened at-risk communities according to the level of observed trachoma prevalence in children aged 5–9 years by region, Western Australia, 2024

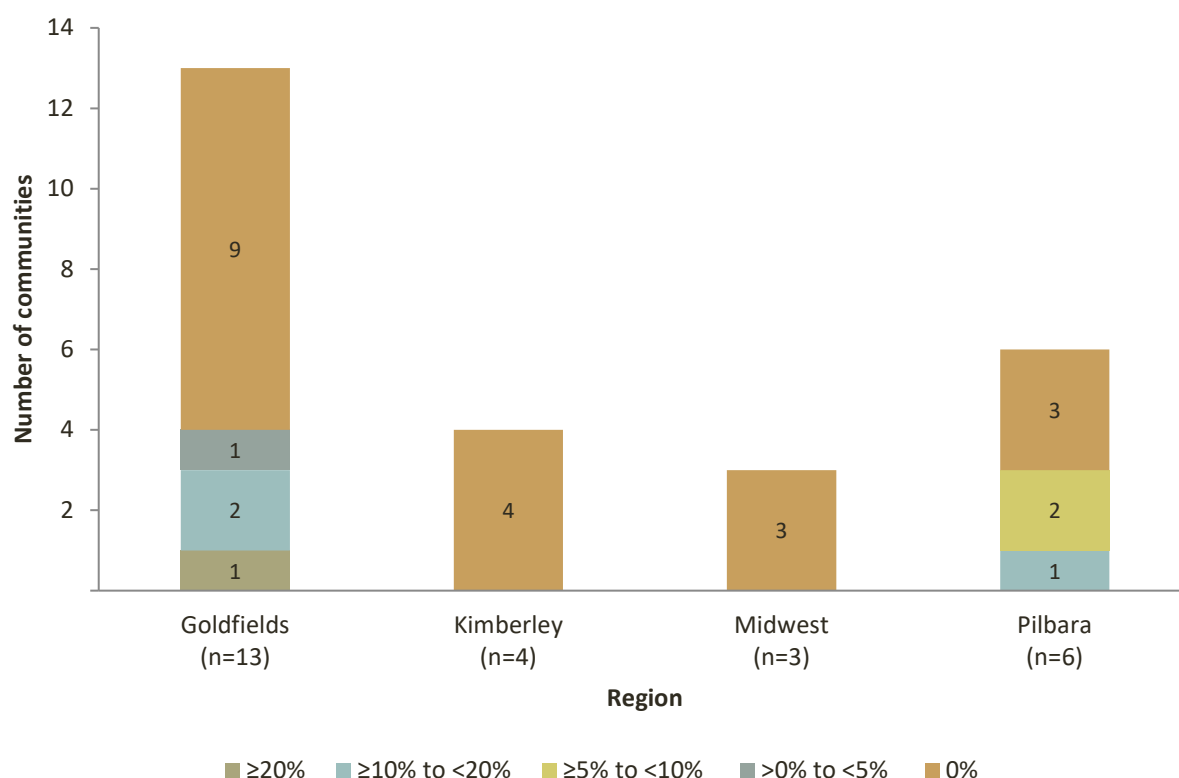
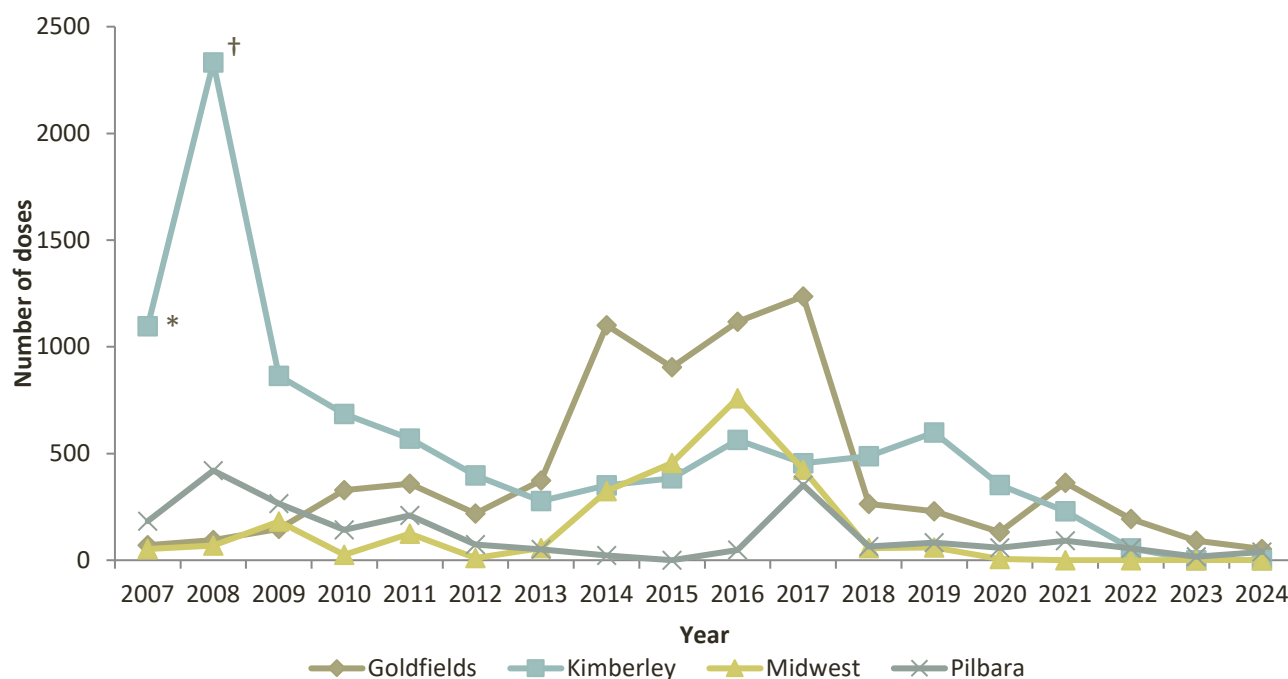


Figure 5.7 Number of doses of azithromycin administered for the treatment of trachoma by region, Western Australia, 2007–2024



* Treatments administered in the Kimberley in 2007 are likely to have been under-reported, as treatment data were not received from several communities.

† In the Kimberley in 2008, 17 communities were reported to have received community-based treatment, compared with only 7 in 2009.

Table 5.8 Trachoma control delivery in at-risk communities by region, Western Australia, 2024

Number of communities	Goldfields	Kimberley	Midwest	Pilbara	Total
At risk (A)*	15	7	5	6	33
Requiring screening for trachoma (B)	13	4	3	6	26
Screened for trachoma (C)	13	4	3	6	26
Requiring treatment without screening† (D)	0	0	0	0	0
Received treatment without screening (E)	0	0	0	0	0
Screened and/or treated for trachoma (F=C+E)	13	4	3	6	26
Requiring neither screening nor treatment for trachoma (G=A-B-D)	2	3	2	0	7

* As defined by each jurisdiction.

†As per CDNA Guidelines.

Table 5.9 Trachoma screening coverage, trachoma prevalence, and clean face proportion in children aged 5–9 years by region, Western Australia, 2024

	Goldfields	Kimberley	Midwest	Pilbara	Total
Number of communities screened	13	4	3	6	26
Estimated number* of Aboriginal children in communities	113	133	18	56	320
Children examined for clean face	108	115	18	55	296
Children with clean face	86	103	12	24	225
Clean face (%)	80	90	67	44	76
Children screened for trachoma	108	115	18	54	295
Trachoma screening coverage (%)	96	86	100	96	92
Children with active trachoma	7	0	0	5	12
Observed prevalence of active trachoma† (%)	6.5	0.0	0.0	9.3	4.1
Estimated prevalence of active trachoma‡ (%)	6.5	0.0	0.0	9.3	2.9
Overall prevalence of active trachoma (%)	2.8	0.7	0.0	3.2	1.3

* Jurisdictional estimate.

† Communities that were screened for trachoma in 2024.

‡ Prevalence rate calculations are described in the Methodology section.

Table 5.3 Number and proportion of at-risk communities according to the level of observed trachoma prevalence in children aged 5–9 years, Western Australia, 2014–2024

	2014		2015		2016		2017		2018		2019		2020		2021		2022		2023		2024	
Communities at-risk*	66		58		51		41		42		38		36		34		31		34		33	
At-risk communities not screened or treated without screening†	10		43		15		7		2		3		2		6		4		9		7	
At-risk communities screened	56		15		36		34		40		35		34		28		27		25		26	
Observed prevalence (screened communities only) ‡	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion	n	Proportion
≥20%	2	4%	3	20%	3	8%	6	15%	10	25%	11	31%	8	24%	5	18%	7	26%	2	8%	1	4%
≥10% to <20%	3	5%	1	7%	3	8%	14	50%	4	10%	4	11%	13	38%	10	36%	6	22%	4	16%	3	12%
≥5% to <10%	2	4%	0	0%	5	14%	1	3%	6	15%	3	9%	4	12%	4	14%	2	7%	2	8%	2	8%
>0% to <5%	6	11%	0	0%	1	3%	1	3%	2	5%	1	3%	1	3%	0	0%	0	0%	1	4%	1	4%
0%	43	77%	11	73%	24	67%	12	29%	18	45%	16	46%	8	24%	9	32%	12	44%	16	64%	19	73%

* As defined annually by each jurisdiction.

† As per CDNA Guidelines. Includes communities that were not screened due to logistical or demographic reasons (i.e., no children in the 5–9-year age group).

‡ If more than one screening episode occurs during the calendar year, data from the first screen is used.

Table 5.10 Treatment strategies by region, Western Australia, 2024

Number of communities	Goldfields	Kimberley	Midwest	Pilbara	Total
Required treatment for trachoma	4	0	0	3	7
Treated for trachoma	4	0	0	3	7
Screened and treated	4	0	0	3	7
Received treatment only	0	0	0	0	0
Received 6-monthly treatment	0	0	0	0	0
Did not require treatment	9	4	3	3	19
Treated active trachoma and household contacts	4	0	0	3	7
Community-wide treatment	0	0	0	0	0
Not treated according to CDNA Guidelines	0	0	0	0	0

Table 5.11 Antibiotic distribution and coverage by age and region, Western Australia, 2024

	Goldfields					Pilbara					Total				
Age group (years)	0–4	5–9	10–14	15+	All	0–4	5–9	10–14	15+	All	0–4	5–9	10–14	15+	All
Requiring treatment for active trachoma	0	7	0		7	0	5	0		5	0	12	0		12
Received treatment for active trachoma	0	7	0		7	0	5	0		5	0	12	0		12
<i>Received treatment for trachoma (%)</i>	<i>N/A</i>	<i>100</i>	<i>N/A</i>		<i>100</i>	<i>N/A</i>	<i>100</i>	<i>N/A</i>		<i>100</i>	<i>N/A</i>	<i>100</i>	<i>N/A</i>		<i>100</i>
Estimated community members* requiring treatment	7	5	10	37	59	4	9	4	18	35	11	14	14	55	94
Number of community members who received treatment	7	4	9	26	46	4	9	4	17	34	11	13	13	43	80
<i>Estimated community members who received treatment (%)</i>	<i>100</i>	<i>80</i>	<i>90</i>	<i>70</i>	<i>78</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>94</i>	<i>97</i>	<i>100</i>	<i>93</i>	<i>93</i>	<i>78</i>	<i>85</i>
Number of community members that refused treatment	0	1	1	10	12	0	0	0	1	1	0	1	1	11	13
Total number of doses of azithromycin delivered	7	11	9	26	53	4	14	4	17	39	11	25	13	43	92
<i>Estimated overall treatment coverage (%)</i>	<i>100</i>	<i>92</i>	<i>90</i>	<i>70</i>	<i>80</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>94</i>	<i>98</i>	<i>100</i>	<i>96</i>	<i>93</i>	<i>78</i>	<i>87</i>

* Estimated as per CDNA Guidelines.

Table 5.12 Trachomatous trichiasis (TT) screening coverage, TT screened proportion, and surgery among Indigenous persons by region, Western Australia, 2024

	Goldfields		Kimberley		Midwest		Pilbara		Total		
Number of communities screened for TT	2		42		4		14		62		
Age group (years)	15–39	40+	15–39	40+	15–39	40+	15–39	40+	15–39	40+	15+
Adults examined*	5	111	38	1502	1	71	1	584	45	2268	2313
With TT †	0	0	0	0	0	0	0	0	0	0	0
With TT (%)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Surgery in past 12 months‡	0	1	0	2	0	0	0	1	0	4	4

* This number may not account for all adults who may be examined in routine adult health checks and may also include multiple screenings per patient. Screening is linked to trachoma endemic regions and does not consider changing endemic regions over time and transiency between regions.

† Defined as cases 'previously unknown to the health system'.

‡ Surgery may include cases identified in previous years.

Table 5.13 Health promotion activities by region, Western Australia, 2024

	Goldfields	Kimberley	Midwest	Pilbara	Total
Number of communities that reported health promotion activities	14	12	7	15	48
Total number of programs reported	18	20	12	28	78
Methods of health promotion					
One-on-one discussion	1	11	7	6	25
Presentation to group	18	19	7	12	56
Interactive group session	0	0	0	8	8
Social marketing	0	0	0	0	0
Print material/mass media	0	0	0	0	0
Sporting/community events	0	0	0	1	1
Other	3	0	1	7	11
Target audience					
Health professionals/staff	1	10	1	6	18
Children	14	11	7	14	46
Youth	0	0	1	0	1
Teachers/childcare/preschool staff	3	9	0	10	22
Caregivers/parents	3	0	3	1	7
Community members	1	0	1	8	10
Community educators/health promoters	0	0	0	0	0
Interagency members	3	0	0	0	3
Frequency of health promotion activities					
Once	11	8	6	21	46
Occasional *	7	8	6	5	26
Regular†	0	4	0	2	6
Ongoing/routine	0	0	0	0	0

* 2–4 times per year.

† 5–12 times per year.

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