TRACHOMA ELIMINATION IN AFRICA
LESSONS FROM TWO MULTI-COUNTRY INITIATIVES

Review conducted by **TROPICAL HEALTH**

Contents

Effective programme delivery: quality, coverage and equity across the SAFE strategy

Building health systems to sustain elimination

A unique partnership model

Summary of key lessons

Acknowledgements

Introduction

In 2014, The Queen Elizabeth Diamond Jubilee Trust (the Trust) and the UK Department for International Development (DFID) initiated two ambitious five-year programmes to tackle trachoma across ten countries in Africa. With a total budget of £80 million, the two initiatives aimed to make significant progress towards, or achieve elimination of, trachoma as a public health problem in the selected countries. Working with the support of members of the International Coalition for Trachoma Control (ICTC), these two programmes have supported the effective delivery of the SAFE strategy on an unprecedented scale. The results achieved have built upon the significant steps taken towards global elimination of trachoma in the past two decades.

As these two programmes come to their close in 2019, an end-of-programme evaluative learning exercise (Learning Exercise) was commissioned. The aim of this Learning

Exercise was to generate strategic learning to contribute to available evidence about trachoma elimination, neglected tropical disease (NTD) strategy and programming, and the broader health sector. The Learning Exercise particularly sought to advance understanding in areas where there are gaps in knowledge, with the hope of informing global strategies to achieve the elimination of trachoma.

Using a participatory approach, the Learning Exercise identified, explored and documented examples of good practice, what worked well and what could have been done differently. The learning described in this paper was collected through a review of key documents; written survey responses; and key informant interviews, focus group discussions and workshops with stakeholders at global, regional and country levels. Conclusions reflect the perceptions of participants in the Learning Exercise.
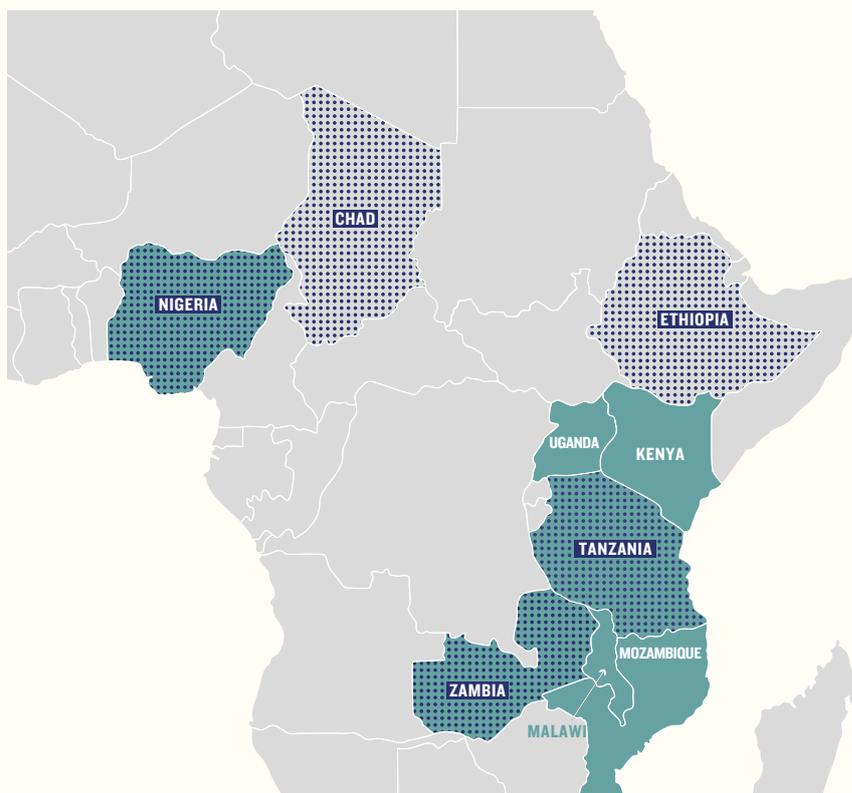
Areas of trachoma work by DFID and the Trust in Africa

Key

Trust supported countries

DFID supported countries
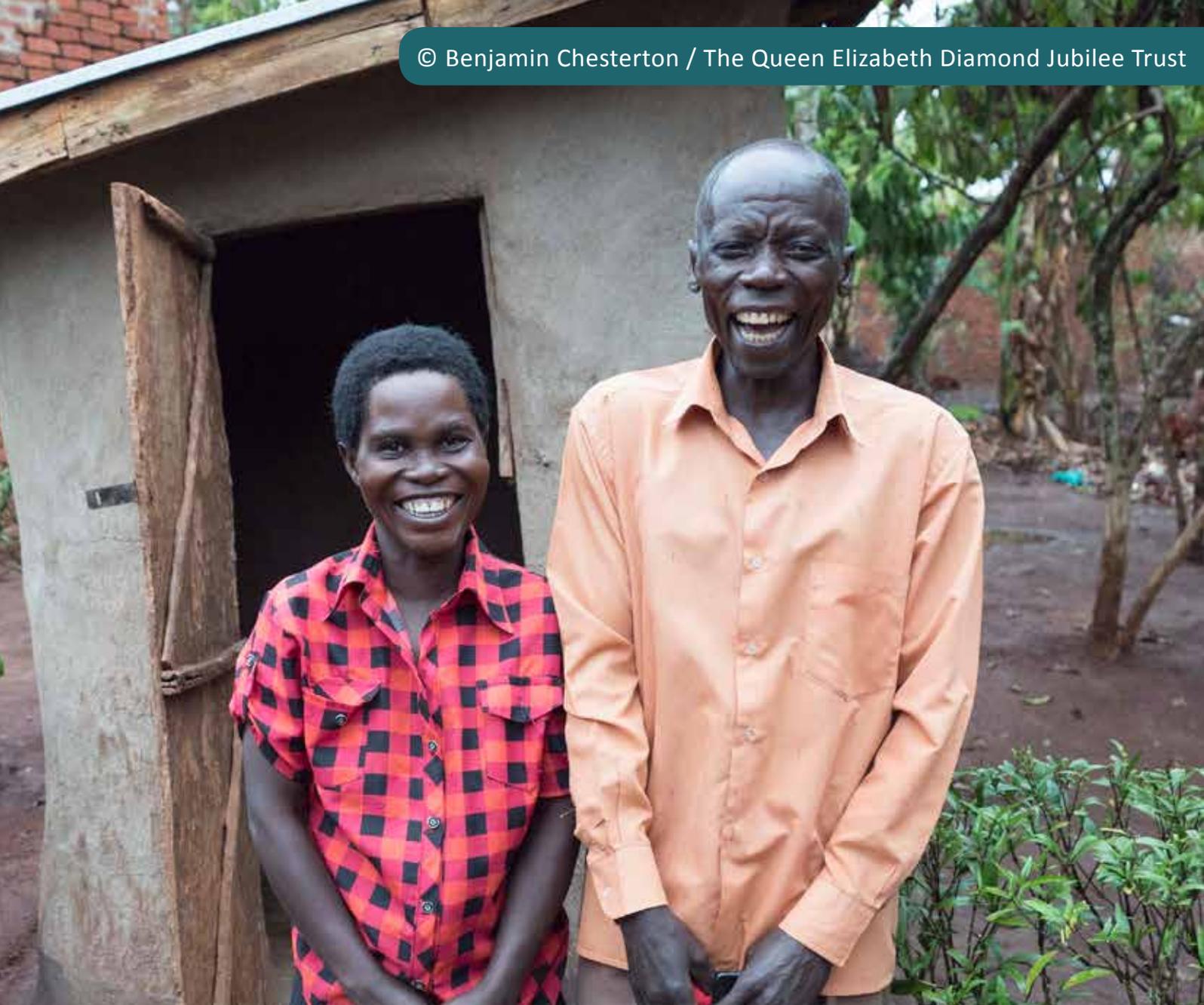
Eliminating trachoma as a public health problem

Trachoma is the world's leading infectious cause of blindness and one of 20 neglected tropical diseases. An estimated 158 million people live in trachoma-endemic areas where it is a significant health and development issue. Trachoma is caused by bacteria spread through contact with eye or nose discharge from an infected person. In 1998, the World Health Assembly adopted resolution WHA51:11 for the global elimination of trachoma, in support of the World Health Organization (WHO) Alliance for the Global Elimination of Trachoma by the year 2020 (GET2020 Alliance). The WHO-endorsed SAFE strategy provides a framework for treating and preventing trachoma. The strategy consists of Surgery to correct the effects of *trachomatous trichiasis* (TT), the late, blinding, stage of trachoma; Antibiotics to reduce the prevalence of active disease; and Facial cleanliness and Environmental improvement (F&E) to limit transmission and sustain trachoma elimination.

Progress towards trachoma elimination

1993

The WHO adopts the SAFE strategy as its recommended elimination approach

1996

The WHO Alliance for the Global Elimination of Trachoma by 2020 (GET2020 Alliance) is launched

1998

The International Trachoma Initiative (ITI) is founded to manage antibiotics donated by Pfizer Inc.

1998

The World Health Assembly adopts a resolution targeting trachoma for global elimination

2004

The ICTC is established as a stakeholder membership of non-governmental, donor, private sector and academic organisations working together to support the WHO GET2020 Alliance

2011

The ICTC publishes 'The End in Sight: 2020 INSight', a global strategic plan that outlines a roadmap, setting out actions needed to achieve the global elimination of trachoma by the year 2020, including a plan for how to collaborate and invest through large- scale partnerships

2012

The London Declaration on Neglected Tropical Diseases brings global partners together targeting ten NTDs, including trachoma, for control, elimination or eradication

2012–2016

DFID and USAID-funded Global Trachoma Mapping Project collects trachoma data from 2.6 million people in 29 countries

2012

Oman becomes the first country to achieve WHO validation for having eliminated trachoma

2014

DFID and the Trust commit a combined £80 million to eliminate trachoma over five years across nine African countries (later expanded to a tenth country)

2016

The WHO GET2020 Alliance launches 'Eliminating Trachoma: Accelerating towards 2020', outlining a plan of action to scale- up programmes and strengthen health systems

2016

Morocco achieves WHO validation for having eliminated trachoma

2017

Mexico, Cambodia and Laos receive WHO validation for having eliminated trachoma

2018

Ghana becomes the first country in WHO Africa Region to eliminate trachoma; Nepal and Iran also achieve WHO validation of elimination

An unprecedented partnership

The two programmes partnership model was unique and complex. The programmes were overseen by an ICTC programme advisory committee, led by a nominated grant manager (Sightsavers), and involved the unusual mechanism of ICTC members in the roles of country coordinating and implementing partners who collaborated closely with the health ministry in each country.

Alignment between the two funders, and more broadly within the trachoma community, has been a goal from the onset of the programmes, and drives the core principles of the initiatives. The partnership aimed to have an impact at three levels:

- **On-the-ground achievements in trachoma-affected communities** by scaling up the SAFE approach and ensuring quality and efficiency;

- **Strengthening health systems** such that achievements and elimination can be maintained;

- **Influencing others** through the development of new approaches, toolkits and data for decisions and resource mobilisation.

© Ashley Gilbertson / VII / The Queen Elizabeth Diamond Jubilee Trust

PROGRAMME ACHIEVEMENTS

213,886
sight-saving
surgeries conducted

153
districts that benefited
from facial cleanliness
and environmental
improvement activities

68,571
case finders mobilised to
locate people in need of
treatment across 70
districts/regions

75.7 MILLION
vital antibiotic treatments
provided to people living
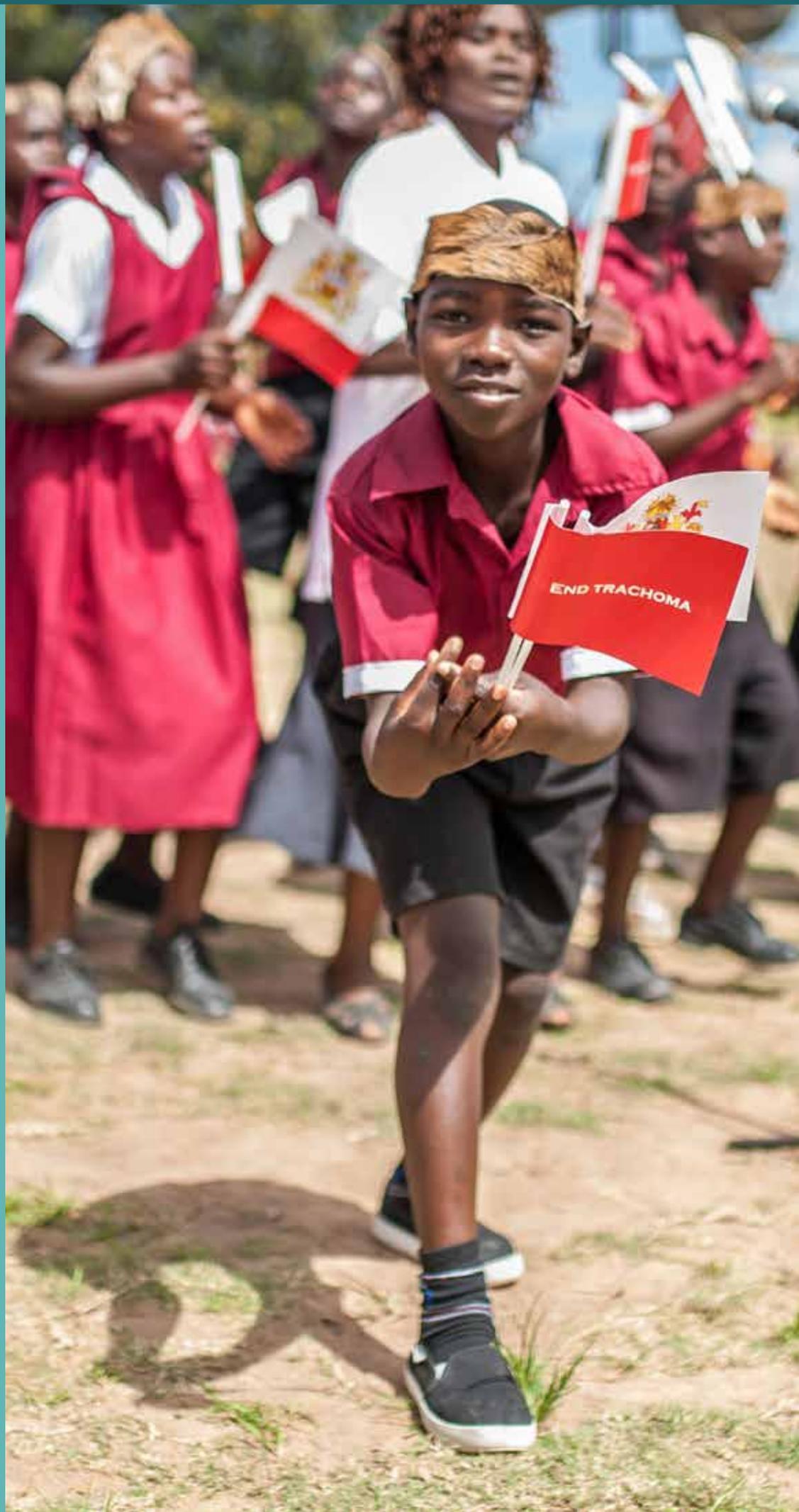in high-risk areas

82
organisations involved, including
government ministries, coordinating
partners, global partners, donors
and international bodies

EFFECTIVE PROGRAMME DELIVERY: QUALITY, COVERAGE AND EQUITY ACROSS THE SAFE STRATEGY

Lesson I: Agreeing and adopting preferred practices is key to progress

Through the ICTC, the trachoma community has agreed and produced a collection of preferred practices, manuals designed to share evidence of what works based on operational research and on country experience (see page II). Some of these resources document clearly agreed best practices (for example, with regards to the TT case finders' curriculum); others offer a toolbox of options. The development and adoption of preferred practices is a dynamic, evolving process. The practices are the product of on-the-ground experience from trachoma elimination programmes and ICTC members. Preferred practices are then put forward, advised on by the WHO and formally agreed by the ICTC members. Countries subsequently adopt and implement them, experiment and test approaches, and continuously inform the development of new preferred practices. ICTC preferred practices are therefore not intended to be prescriptive. Countries are expected to adapt these practices and test new approaches, as appropriate for their context. Overall, the use of standardised tools and the development of preferred practices were perceived to be effective strategies for reaching elimination targets. Successful uptake of ICTC preferred practices was enabled by:

Health ministry leadership:

Health ministries generally adopted the preferred practices for trichiasis case management and mass drug administration as national guidelines, a process which supported their consistent implementation as quality standards. The national Trachoma Task Forces – government coordination bodies set up in trachoma-endemic countries, consisting of government representatives, NGOs, donors, academic institutions and other stakeholders – played important technical advisory roles to support the adaptation of preferred practices to national context. For example, in Ethiopia, the National Trachoma Task Force led the adoption of supportive supervision preferred practices and tools.

Consistent support from country coordinating partners:

Coordinating partners supported health ministries to ensure implementing partners followed a common, evidence-based approach.

Quality technical assistance:

Technical advisory visits by master trainers or a senior expert, were an important mechanism to support and monitor the implementation of preferred practices in the field. Hands-on capacity building was highly valued by health teams, especially TT surgeons. Assistance was most effective when followed by written recommendations and debriefing meetings, to support ongoing monitoring and evaluation.

Documenting and sharing evidence:

Quarterly review meetings involving National Trachoma Task Force members, and the coordinating and implementing partners, were useful for sharing experience and demonstrating the effectiveness of preferred practices.

"We had to talk about preferred practices again and again, at every review meeting. A turning point was when we showed evidence that case finding strategies were more successful than mass mobilisation strategies; then we got traction." – Coordinating Partner

Although the adoption of ICTC preferred practices was key to progress, uptake was too slow in some countries.

Factors which delayed or impeded the uptake of preferred practices or other standardised tools included:

Late sharing or initial absence of guidance

At the start of these programmes, there was little guidance available on transitioning services post-elimination on surgical audits. The programmes made an important contribution to developing new toolkits or preferred practices for these areas. Although it was acknowledged that developing preferred practices is a work in progress, in some cases, late sharing or additions to preferred practice manuals slowed implementation.

Weak or inconsistent governance

Where health ministry involvement was weak (in part due to high staff turnover) or governance structures shifted, uptake of preferred practices was impacted due to limited capacity to adopt, promote and adapt use over time.

Resistance to change and limited accountability

Some implementing partners were seen as resisting change, ignoring the evidence or ICTC preferred practices and continuing to undertake activities in a business as usual approach. This may have related to some partners limited technical expertise or understanding of specific preferred practices. Some global experts also noted that there was no accountability mechanism for ensuring partners implemented the preferred practices.

Current ICTC preferred practices

- Preferred practices for Zithromax® mass drug administration (2013)
- All you need for F&E – a toolkit for planning and partnering (2015)
- Organising trichiasis surgical outreach - a preferred practice for programme managers (2015)
- Trachoma action planning – a planning guide (2015)
- Micro-planning for effective Zithromax® mass drug administration (2016)
- Training curriculum for trichiasis case identifiers (2016)
- Trichiasis counselling guide (2016)
- Supportive supervision for trachomatous trichiasis programmes (2017) and for mass drug administration (2018)
- Training trichiasis surgeons for trachoma elimination programmes (2018)
- Transition planning for trichiasis management services (2019)
- Transition planning for mass drug administration of Zithromax® (2019)
- Transition planning for facial cleanliness and environmental improvement (2019)

Lesson 2: Standardisation of quality assurance measures improve surgical performance and overall quality of care

All countries made considerable progress in adopting and implementing quality assurance and safety measures across the SAFE strategy. There was evidence of broad "buy-in" for quality improvement approaches. This has been exemplified by the progress made to improve the surgical performance of TT surgeons and the overall care experience of TT patients. In particular, the standardisation of quality assurance approaches – beginning with training and certification, and followed by supportive supervision, monitoring of follow-up rates, assessing post-operative outcomes and surgical audits – was perceived to improve surgical performance and overall quality of care. Participants identified the following good practices supporting surgical quality:

Developing certified surgical staff

Developing awareness of the need for surgical training:

In some countries, stakeholders needed to first address assumptions regarding surgical qualifications, skill levels and the need for training.

Standardising the training process at all stages:

This included ensuring that training of trainers is conducted by master trainers and that trainings combine live surgery practice with the use of HEAD START, a mannequin designed as a training device for trichiasis surgery. Global experts emphasised that all trichiasis surgery training, including training of trainers and training of supportive supervisors, should first be classroom-based, using HEAD START, and should include live surgery practice under supportive supervision from a master trainer.

"We were taught about trachoma and TT surgery during our initial training. But when we took the certification process […], some of us did not manage to pass the certification. So, [this additional training was important], to ensure good quality surgery!"
– Ophthalmic Nurse

"It was always assumed that health workers would have adequate knowledge from their training programmes. But this was not the case. Knowledge on basic details was missing in health workers, including how and where TT can be managed and how it could be prevented. All clinical staff had no modern skills in operating a TT case. They all needed training to be able to operate a TT case."
– Implementing Partner

Conducting regular supportive supervision

Consistent supportive supervision for both quality assurance and technical capacity building is now recognised as a key programmatic element by most countries. Providing specific training to supervisors on how to conduct supportive supervision is important for ensuring and maintaining quality over the long term. Ophthalmologists were initially targeted to provide supervision. This posed a challenge in some countries, as they have both limited availability and, in some contexts, limited exposure to TT surgery. Alternative selection strategies, such as engaging lower level health workers who have the required skills, were identified as good practices in some countries.
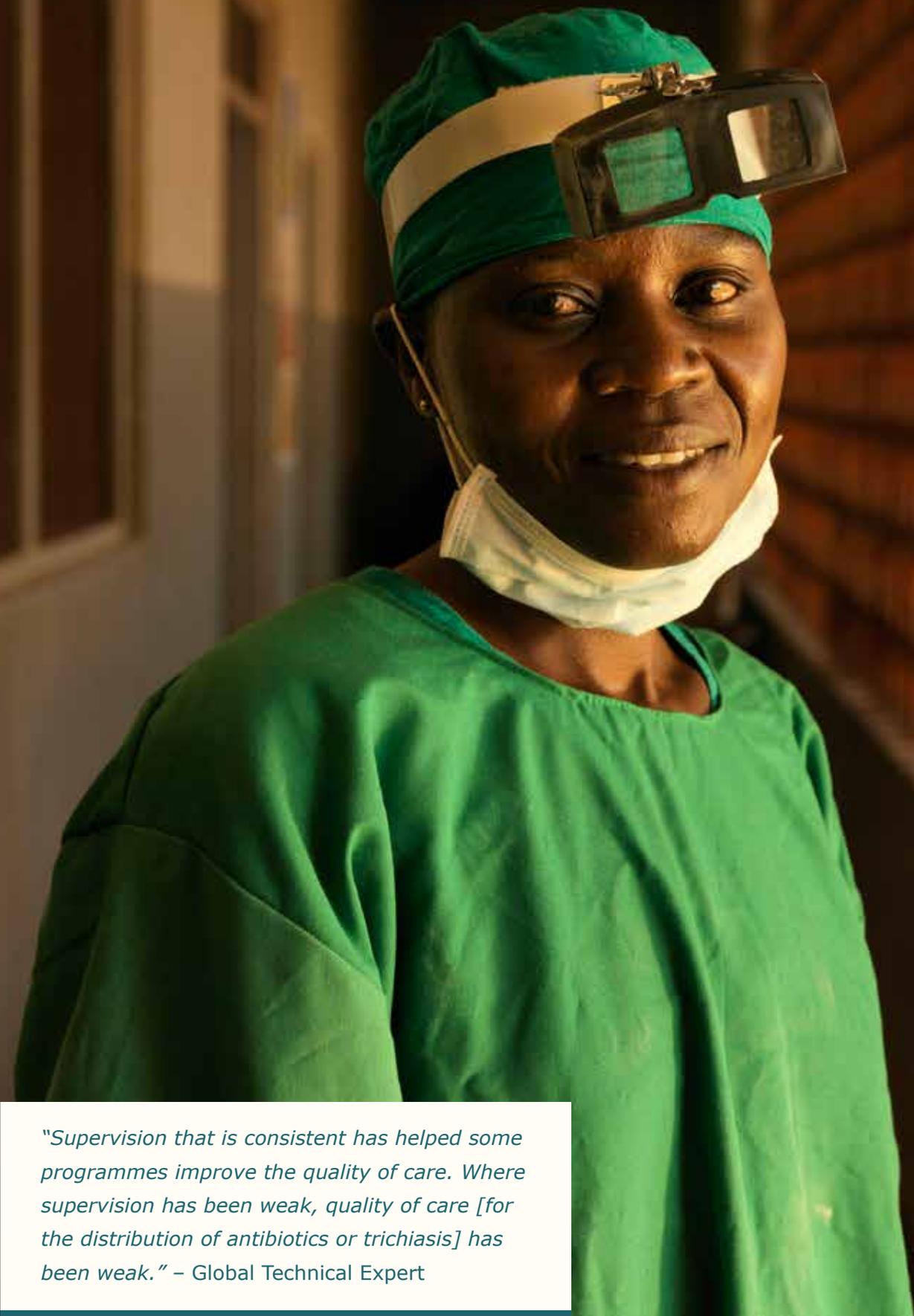
"*Supervision that is consistent has helped some programmes improve the quality of care. Where supervision has been weak, quality of care [for the distribution of antibiotics or trichiasis] has been weak.*" – Global Technical Expert

Post-operative assessments

The programmes placed an emphasis on improving the assessment and reporting of surgical outcomes, the final outcome being determined at the three- to six-month post-operative follow-up visit. However, there was wide variation across countries in the proportion of patients completing the recommended three- to six-month follow-up visit. While programmes strive for completion of all recommended follow-up visits, it was acknowledged that rates of completion at three to six months will vary according to context, health seeking behaviour norms, and available human and financial resources. Programmes should have appropriate mechanisms in place to support compliance with follow-up visits. Strategies to support adherence included:

• Post-operative counselling

• Providing appointment cards to patients after surgery

• Using mass communication channels to underline the importance of follow-up

• Working with the case finders who previously identified patients to remind patients where to go for check-up

• Conducting home-based follow-up visits for elderly patients

• Using TT outreach camps as an opportunity to also conduct post-op follow-up

• Using the "TT surgery tracker", a mobile phone-based application, currently being piloted, to track surgical outcomes within the global elimination programme.

Introducing surgical audits as a complementary approach

A surgical audit is an additional, standardised tool for monitoring the quality of surgeries being conducted. It complements outcome assessment (which provides information for patient management). Surgical audits aim to assess the actual outcome of surgeries performed by an individual surgeon, to determine if the surgeon needs additional training. This involves register review and case follow-up, using lot quality assurance sampling methods. A guide for this approach was developed during the programme and is in the process of being adopted as an ICTC preferred practice. Most countries have now piloted this process. Monitoring of post-operative outcomes using standards of acceptable rates of post-operative TT allowed national programmes to identify poorly performing TT surgeons and retrain or remove them. In two countries, poorly performing surgeons were identified through this process and recommended for removal or retraining by health ministries or district authorities. As regular supportive supervision requires significant time and human resources to conduct, surgical audits are an important complementary quality assurance measure.

"Supportive supervision is critical […] and cannot be replaced by surgical audits. [It] allows for corrective measures to be taken on the spot if needed, [and] for mentoring and support on the job." – Global Technical Expert

Although there was buy-in for effective quality assurance measures (certification, supervision and audit), the following challenges require further attention in surgical quality preferred practices:

• **Human resources and retention:**

In some settings, attrition of TT surgeons impacted performance quality and effective use of resources. Different mitigation strategies were developed, but with limited results. In Ethiopia, integrated eye care workers were posted to their district of origin whenever possible. Although this was a short-term solution to clear the backlog, health ministry representatives believed these workers would continue to support the eye health system over the long term.

- **Post-operative follow-up visits:**

  Although some countries developed creative approaches to support three- to six-month follow-up visit completion, this remains a challenge across contexts. There is a need to identify and test further approaches, as well as to allocate adequate resources to support active patient follow-up where necessary.

- **Surgical audit:**

  The surgical audit guide requires an appropriate sample of operated eyes. Several countries reported challenges with evaluating the performance of surgeons who operate infrequently. Guidance on appropriate sample size is currently under revision.

- **Post-elimination:**

  Assessment of the most appropriate measures for maintaining surgical quality post-elimination (as trichiasis surgeries are rarely performed), and effective integration of these measures into routine health service delivery, require ongoing review.

© Ashley Gilbertson / VII / The Queen Elizabeth Diamond Jubilee Trust

Lesson 3: A systematic approach to case finding is key to equitable coverage

Trichiasis case finding was, and is still, a challenge, but a more systematic approach has led to improvements. A door-to-door approach (covering an entire administrative zone) has helped to achieve full coverage, generate good data that can be presented in the elimination dossier for validation by the WHO, and ensure that the most vulnerable have the option to access services. However, the door-to-door approach requires considerable human, financial and logistic resources. The cost-efficiency of the approach decreases rapidly as cases decline. The focus has been on hard-to-reach areas, or where the backlog has already been reduced to find the last remaining cases. Some countries conducted microplanning across trichiasis activities which supported the cost-efficient integration of different activities and later integration into routine health services (see page 32). Strategies for case finding need to be adapted and reviewed over the course of programme implementation.

Case finder selection

Most countries followed ICTC preferred practices for case finding and identified groups of community-level volunteers to be trained as case finders as appropriate for the context. These included community health workers or other health volunteers from the sub-district level, as well as teachers and other community leaders. In Tanzania, the involvement of sub-village and microfinance group leaders as supervisors of case finders helped to ensure coverage (see page 24).

Good coverage data

In the early phase of the programmes, countries struggled with inaccurate backlog data. This greatly improved with the standardisation of data under the Global Trachoma Mapping Project and Tropical Data, a WHO-led survey support service for national NTD programmes. Still, in some settings with TT prevalence estimates with wide confidence intervals, it has been difficult to know when the elimination threshold has been reached. The use of a systematic case finding process has allowed countries to be definitive about geographical coverage, and more confident about having reached the elimination threshold. However, countries struggled with the best ways to document case finding. Some noted that it was very challenging to develop new approaches during implementation. In Uganda, the team developed a systematic method, using Excel, to document the process of conducting house-to-house case finding in districts where the 0.2% target had not been met. This approach could be adapted or inspire the development of other tools to collect information as relevant to specific contexts. More guidance and exchange of on-the-ground experience is needed on the best ways to document case finding and how countries entering the end phase should document the last steps.

"There's still debate about how we confirm that we actually finished with surgery. The data are telling you one thing and experience is telling you another… TT prevalence is usually not reflective of what is happening on the ground. So, we developed a process for systematically documenting that patients are being looked for." – Coordinating Partner

"House-to-house trichiasis case finding has been crucial to achieving full and equitable coverage of a district." – Global Technical Expert

Lesson 4: Preferred practices and guidelines for MDA have led to rapid progress, but tailored practices for hard-to-reach populations are needed

The programmes were very successful in implementing mass drug administration (MDA) campaigns, and in collaborating with complementary programmes implementing MDA campaigns. This has led to rapid progress in reducing the burden of active trachoma. High quality and coverage were enabled by:

The adoption of ICTC preferred practices and International Trachoma Initiative (ITI) guidelines

Comprehensive training
of MDA supervisors and community drug distributors.

Effective microplanning
and district ownership of the process.

Supportive supervision:
Regional training of trainer workshops on supportive supervision were conducted, and replicated in many countries, such as Nigeria and Ethiopia.

Multifaceted social mobilisation strategies:
In most countries, different strategies were used to mobilise communities, combining mass communication and targeted health education and involving trusted local and religious leaders. In Ethiopia, door-to-door approaches based on existing mapping were also used to help achieve optimum coverage.

Dissemination and adoption of ITI guidelines regarding azithromycin dosage and administration:
While severe adverse effects are very rare, a few cases have been reported. Retraining of supervisors and community drug distributors was undertaken in Zambia to ensure universal adoption of safe practices when giving Zithromax® to children (e.g. not blocking the nose when administering the drug).

Use of efficient mop up strategies and tools to increase coverage
The need for effective mop up strategies is recognised, and tools have been developed to support this. In Ethiopia, a rapid coverage supervision tool was developed by the Federal Ministry of Health and the WHO, based on one used for other NTDs. The tool supports the validation process to determine if mop up is needed.

High drug acceptability

Zithromax® is well-accepted by populations. In Nigeria, "people like Zithromax®".

Good coordination with those doing MDA for other diseases

(see page 30)

Despite the wide success of the campaigns and high overall MDA coverage, some challenges remain in reaching populations considered difficult to access. These include those in remote locations, nomadic populations with limited opportunities for effective MDA, and populations affected by displacement or living in insecure settings. In northern Tanzania, spot checks revealed the presence of trachoma hotspots at the sub-district level, while in Zambia reaching elimination of active trachoma in the Western Province remains challenging. Certain areas have a configuration of some, or all, of the following constraining factors for MDA: low population density, insecurity, roads that can be impassable for part of the year, no mobile phone coverage as a barrier to real-time campaign adjustments, difficult access to water and challenging environmental conditions.

Identifying and documenting innovative practices to serve hard-to-reach populations is still a work in progress

In Chad, the programmes adapted strategies to use dedicated mobile teams, rather than community volunteers, to reach nomadic populations across vast, hard-to-reach areas. With funding from DFID, the Coalition for Operational Research on NTDs is currently supporting several operational research projects on equitable access to MDA for NTDs worldwide. Future programmes will need to use this evidence base to adapt approaches depending on the context, such as fragile states or sub-regions with transient populations.

"Programmes need to go out of their way to locate and educate disadvantage groups [through working with local leaders and community health workers] … It will not happen automatically with mainstream activities." – Coordinating Partner

Lesson 5: Making gains sustainable requires ongoing F&E investment and strong intersectoral collaboration

The strategic approach of partnering and creating linkages with various sectors – including the Water, Sanitation and Hygiene (WaSH), education and wider health sectors – to embed trachoma-related messages in ongoing work and support the enabling environment was valued. It was widely acknowledged that the SAFE strategy clearly defines an approach for incorporating trachoma-related hygiene and sanitation issues into existing programmes rather than creating a trachoma-specific F&E programme. In countries where the programmes are operating, WaSH and education actors now place greater importance on their respective roles in eliminating trachoma.

Appropriate timing, technical expertise and knowledge of WaSH programming

Across countries, implementation of the F&E component started late and did not have sufficient time to effect meaningful change. Although this phased approach was not by strategic design, considerable time and resources were required to understand the operating context and develop appropriate approaches. There was wide agreement **that all four SAFE components should be implemented from the start,** and that this alignment was crucial for allowing adequate time for F&E to achieve results and to create the intersectoral linkages to sustain elimination.

"All of the elements [of the SAFE strategy] are challenging. But we underestimate what needs to be done to get F&E experts in... If we are looking at doing all of this work again, we would start with F&E because that's the key."
– Global Technical Expert

Initial challenges included **limited technical capacity and familiarity** with WaSH and behaviour change programming. While some countries' implementing partners included WaSH organisations, F&E was a new area for many coordinating and implementing partners, who had considerable eye health and service delivery experience but less technical expertise and lay-of-the-land knowledge of WaSH and behaviour change programmes and actors in-country. Technical expertise was later brought on at the grant manager level, which was highly valued and utilised. However, it was challenging for two people to support more than 30 WaSH partners across ten countries. In some countries, reputable WaSH NGOs were successfully engaged as technical leads, which was perceived to be an important success factor. It was also suggested that coordinating partners might benefit from having WaSH and behaviour change technical advisors on staff, to more effectively engage, support and supervise F&E partners. There is a need for all actors to understand how the WaSH and behaviour change activities contribute to the overall goal.

"It is its own sector with its own jargon and own way of doing things. We did not have any WaSH-experienced staff at country level. They [WaSH technical advisors at Grant Manager level] were limited because they were supporting so many counties. To do things differently, if we are going to be managing all these different partners – five WaSH organisations – it would have been good at the Coordinating Partner level to have someone with WaSH expertise on staff. We probably missed some opportunities to fine tune the programme better because it's a sector we're not familiar with." – Coordinating Partner

Partnering on policy, strategy and communication

Different approaches to partnering on F&E activities were taken in different countries. These included engaging WaSH NGOs as implementing partners and working with NTD NGOs with WaSH expertise. Identified good practices and achievements included:

• **Developing structures at national and sub-national levels for intersectoral coordination and advocacy:**

In Ethiopia, a WaSH-NTD technical working group was created and has developed a toolkit outlining roles and responsibilities from national to district level; a WaSH focal point was also appointed in the NTD department. In Kenya, County Trachoma Task Forces were established at sub-national level, as an extension of the National Trachoma Task Force, with government and NGO representatives from the health, water and education sectors. These teams advocated for resource allocation and integration in their counties' strategic development plans, leading some counties to allocate resources for water infrastructure.

• **Embedding trachoma in WaSH strategies, policies and guidelines:**

For example, in Tanzania, National Community-Led Total Sanitation guidelines now include behaviours related to trachoma. In Malawi, trachoma prevention is included in the national WaSH and Open Defecation Free (ODF) strategies, Community-Led and School-Led Total Sanitation guidelines. Previously, face washing was not included in most frameworks. In Ethiopia, a school health programme, "One wash", was launched and includes topics on sanitation, health, NTDs and environmental health.

• **Engaging ministries of education to develop school curricula:**

In several countries, including Chad, Ethiopia, Malawi, Tanzania and Uganda, trachoma-related messages were added to the national school health curriculum and sanitation guidelines. In Ethiopia, the programme collaborated with the Ministry of Education on F&E intervention design and implementation, engaging experts on early child education to develop an innovative approach for targeting young schoolchildren (see page 23).

• **Developing behaviour change communication (BCC) strategies through an intersectoral process:**

In Chad, Ethiopia and Uganda, BCC strategies and F&E activities were designed through intersectoral, collaborative processes, which helped to build consensus and buy-in from all stakeholders.

• **Partnering with communications experts to develop advocacy tools:**

In Uganda, a trachoma video documentary was developed as a tool for advocating for increased resource allocation and integration of F&E communication in district health programmes.

"It is important that they feel that including trachoma F&E information is now part of what they do as a WaSH NGO."
– Coordinating Partner

"This [collaboration] has been a key output and probably a pioneering effort to bring various sectors together. Multisectoral approaches are still relatively new and this was vital to obtain buy-in by other sectors and leverage their strengths."
– National Trachoma Programme Officer, Ministry of Health

In some countries, there were initial challenges in selecting and developing working relationships with WaSH partners. The following good practices for successful partnership were identified:

• **Have a "welcoming attitude" and reach out to the WaSH sector:**

The trachoma community needs to convince the WaSH sector of the benefits of collaboration, what is in it for them.

• **Value WaSH partners' expertise:**

In some countries, it was reported that WaSH partners' suggestions for developing innovative approaches or adapting preferred practices were not initially supported; some coordinating partners noted that they may have sometimes pushed back or questioned WaSH partners due to their own limited technical knowledge.

• **Acquire knowledge of existing relationships between WaSH NGOs prior to partner selection:**

Some early programme management and contracting mistakes were identified in one country, resulting from insufficient knowledge of existing relationships between local WaSH NGOs.

"It's getting a place at the table. We're not experts in that field [WaSH], we need to know who those experts are and convince them that it is a good thing to join and what we can offer them. We thought they would come and sit with us, but now we know, we need to go and sit with them and bring these people on board. It's the bit that has taken the longest and also the bit that is vital to elimination."
– Global Technical Expert

Additional challenges that require further attention include:

• **Partners learned by doing with regards to F&E partnering. There was a clear need for more technical expertise and structured guidance on how to develop and sustain meaningful intersectoral collaborations:**

On 31 January 2019, a new toolkit developed by the WHO and the Neglected Tropical Disease NGO Network (NNN) was launched, "WaSH and Health working together: a practical guide for NTD programmes", which aims to address this gap.[i]

• **The programmes' intersectoral approach to behaviour change and support of the enabling environment through improved coordination was considered a key strength.**

However, some questioned whether the "soft" approach was sufficient, or if "hard" components (physical infrastructure) should also be supported.

In some cases, this may have related to a limited understanding of the programmes' F&E strategic approach, but this view also reflected the water-stressed environments of some trachoma endemic communities.

---

i *WaSH and Health working together: a practical guide for NTD programmes.* https://www.who.int/water_sanitation_health/diseases-risks/diseases/wash-health-toolkit/en/

- **More evidence is needed on what works well and how to measure success**

There is a need for operational research to refine the BCC strategies that work best in each context, and to examine other F&E strategies, including the most effective ways to control flies. Though the S and A components were very output driven, the programme initially struggled to measure F&E performance. This improved following the introduction of an F&E monitoring and evaluation framework, which provided specific F&E indicators. Discussion and agreement on the most useful indicators for monitoring progress is ongoing.

"[We] still don't know what a good [F&E] BCC programme is. How do you measure it? [...There is a] big debate on indicators."
– Global Technical Expert

Ethiopia: An innovative approach to promoting facial and hand cleanliness among young schoolchildren

In Tigray, it was identified that the existing F&E school curriculum was too complex for pupils below the age of six years. An intervention targeting schoolchildren aged four to five was piloted in five schools, using methods designed to engage children emotionally and incorporate positive behaviours into children's routines. The approach was developed in collaboration with an early childhood development specialist. It involved observation by children and teachers of facial and hand cleanliness (using mirrors, hands and face charts) and the delivery of key messages via the creation of a character, "ToTo", to teach children healthy behaviours and allow them to be problem solvers. Four different scripts using ToTo were developed and teachers were trained on how to use these scripts and implement this approach. School and community representatives were trained together as a unit to promote joint planning of hygiene and sanitation improvement activities. Monthly meetings were held between the schools and communities to identify ways they could support each other. Teachers and parents observed significant improvements in children's behaviour.

"Before, due to the situation (we have cold weather and difficulties to find water), I was not paying so much attention to personal hygiene. Now, because my children asked me to wash their hands and faces before going to school, saying it was important for their health, I am paying much more attention to hygiene."
– Father of a student

Lesson 6: Reaching trachoma elimination requires an explicit focus on equity

The principle of equity was well understood and ensured in programme implementation through different strategies, largely based on context. National programmes had to monitor and address several equity aspects associated with the coverage of trachoma interventions, such as gender, sociocultural and socioeconomic/vulnerability factors, water and sanitation context, and, in some countries, issues of migration, disasters and conflicts.

Key good practices supporting equitable access to services included:

- **Recruiting more women** as TT case finders and community drug distributors.

- **Systematic case finding approaches,** involving zoning and door-to-door visits (see page 16).

- **Reducing physical and cost barriers** to accessing surgical services for the most vulnerable, such as the very poor, elderly and persons with disabilities. In most countries, accessibility was facilitated through outreach surgical camps located close to communities, no cost for surgical services at the point of use, and support for transport to services for the elderly and disabled.

- **Cross border meetings** for the East Africa Region were held annually to plan how best to reach nomadic populations through joint/coordinated outreach camps, follow-ups and MDA.

- **Dedicated mobile teams** for MDA in hard-to-reach areas (Chad) and for trichiasis surgery, in addition to outreach and static sites (Ethiopia).

Tanzania: Reaching women through microfinance groups

Among the Masai population in northern Tanzania, implementing partners observed that, historically, fewer women had access to eye care and trichiasis surgical services compared to men. To address this imbalance, the programme identified and trained microfinance group members in the Masai community to encourage female community members who had trichiasis to seek surgery. Microfinance group members worked as volunteers and were trained in trichiasis case identification and counselling. Women in the groups who had successful surgery, known as trachoma ambassadors, were utilised to raise awareness and encourage others to make use of available services. Microfinance groups have well-established structures and systems which facilitated case finding. The members were well known and respected in their communities and were very proud to assist the programme.

Future programmes should consider ways to reach the following populations and contexts to ensure no one is left behind:

- **Nomadic populations:**

  Much has been done to coordinate cross-border service provision for MDA and surgical follow-up in the East African countries, but challenges remain for post-op follow-up (see page 14) and in reaching nomadic populations in other countries.

- **Less stable contexts:**

  The programmes have focused on working in relatively stable contexts as a first step towards elimination. Not all neighbouring trachoma endemic countries have yet succeeded in implementing active trachoma programmes. These contexts pose a threat to countries where elimination status has been reached.

- **Supporting persons with advanced disease who can no longer benefit from trichiasis surgery:**

  Limited attention has been given to how best support people who are blind or severely visually impaired because of trachoma. What services can or should they receive?

- **Post-elimination:**

  Although countries are making efforts to plan for and support continued equitable and inclusive access to trichiasis surgery post-elimination, concerns remain about how accessibility and affordability will be maintained as surgical services transition back to routine health system delivery (see page 32).

© Ashley Gilbertson / VII / The Queen Elizabeth Diamond Jubilee Trust

BUILDING HEALTH SYSTEMS TO SUSTAIN ELIMINATION

Lesson 7: Plan for sustainability and health systems strengthening at the outset

The programmes contributed to health systems strengthening, which was considered a key achievement of these initiatives. There was wide agreement that the approach to health systems strengthening should be planned from day one, in order to fully identify opportunities to support the achievement and maintenance of elimination status. This might start with developing a shared understanding of what health systems strengthening means in the context of trachoma. Careful consideration must be given to F&E and the various coordination and integration elements required to support sustainability.

"The approach to health systems strengthening should have been more deliberate and explicit, preferably using the WHO building blocks for health systems strengthening as entry points."
– Global Technical Expert

In some contexts, the work on health systems strengthening was not always explicitly planned at the outset. The decision to identify and support some interventions came late as countries prepared to transition from elimination programmes to routine health services. Though the programmes contributed to all six WHO building blocks of a health system, the scope of system strengthening interventions tended to be more focused on capacity building for trichiasis surgical services. Examples of what worked well and what might be done differently from three key areas of health system strengthening are described below.

Enhancing governance and leadership competencies

The programmes were designed as health ministry-driven initiatives, implemented in support of a country's NTD and trachoma elimination plans. It was widely agreed that, regardless of context, engaging and developing leadership is crucial for the success of trachoma elimination programmes. Good practices for enhancing governance and using a system-wide planning approach included:

• In Ethiopia, national leadership and political commitment have been key to the success of trachoma elimination programmes. The Fast Track Initiative was launched, with strong advocacy at national and regional levels. Secondment of staff at national, regional and zonal levels was perceived to be a key good practice contributing to programme success, especially with regards to health systems strengthening and coordination.

• In Kenya, extension of the National Trachoma Task Force to the sub-national level via County Trachoma Task Forces established an effective governance linkage for delivering the programme.

• The use of agreed upon, authoritative tools for planning purposes, such as the WHO's Framework for Action on Strengthening Health Systems, which facilitated collective situation analysis and consensus-building on the areas to be addressed in countries such as Malawi and Chad. In Kenya, establishing ministry-led thematic working groups aligned with the WHO Framework was also perceived to be a useful planning approach.

• Workshops on leadership and management for trachoma elimination were conducted with funding from ITI for national NTD/trachoma programme managers.

In one country, leadership was inconsistent due in part to the fact that trachoma was moved under different governance structures several times.

"National leadership is a key factor to ensure success of trachoma elimination programmes. In countries where political will or leadership was weak, the programmes faced challenges."
– Global Technical Expert

"Even if the health system is very well developed and you have a problem with leadership and governance, you are not going to make progress. The health system takes its cues from leadership."
– Global Technical Expert

Developing qualified human resources for the long term

The programmes invested considerable resources in the training of different cadres of the health workforce, from community health workers to surgeons, using trainee selection approaches conducive to retention, and training approaches supported by strong technical assistance (see page 12). Investing in the training of new eye care workers, even though this training can take from nine to 12 months, was also critical in some contexts.

- In most countries, community health workers were trained as trichiasis case finders, including training on eye care related information and counselling skills.
- In Ethiopia, all stakeholders emphasised that the programme has supported local capacity building, comprehensively targeting all segments of the community (from community through to district level).

- In Uganda, long-term vision and advocacy by country leadership resulted in the programme having a major impact on strengthening the health system at the district level. The programme invested in a nine-month training course on trichiasis surgery for the existing cadre of Ophthalmic Clinical Officers at district level, allowing this group to gain exposure to trachoma and other eye disease through continuous participation in surgical camps.
- In Chad, general nurses were trained for 21 days to work as TT surgeons, with support from the coordinating partner and the national programme, based on WHO guidelines. Once certified, they signed a one- to three-year contract to remain at the same location, based on TT prevalence.

"[The most important success of the programme was] building the capacity of Ministry of Health and implementing partners to be able to carry on TT work post project implementation. Both at community, district and regional level there is available a group of human resources well knowledgeable about trachoma and management approaches. The Trust/DFID offered to train eye care workers in districts that had none so that they can then be trained in surgery, screening and counselling." – Implementing Partner

However, in at least two countries, initial trainee selection for case finders and surgeons was not aligned with ICTC preferred practices or long-term needs for transition planning. This appeared to be due to a combination of factors, including limited initial awareness and competing approaches between implementing partners. Initial planning mistakes included not training existing community health volunteers, providing incentives to case finders, and selecting surgeons from implementing partners rather than health ministry staff. Although these approaches were changed later in the programme, this affected timely integration of trachoma activities in the health system.

Using data and health information for decision making

There was wide agreement that the programmes were evidence-based and data-driven. Examples of good practices and achievements included:

- Introducing new data collection tools and registers and incorporation of ophthalmology and surgical data in district health information systems.
- Establishing methods for mapping disease, improving the accuracy of backlog data, developing new tools for documentation of case finding and collecting information for dossiers.
- Acting on quality assurance feedback from surgical audits, supportive supervision and other programme data to improve surgical performance.

- Encouraging the use of district-level data (case finders, TT surgeons, district mapping) to plan and review strategy.
- Leadership by the health ministry on monitoring and evaluation improved enforcement of decisions.
- Supporting the presence of data managers at the district level.
- Conducting small operational research studies with actionable results.
- Sharing experience and evidence during quarterly and annual review meetings and other forums.

However, developing skills and capabilities – among both implementing partners and health ministry staff – for interpreting, analysing and cross-referencing data to inform decision-making, rather than just 'reporting', remains a work in progress. In some cases, the use of data for decision making at country level was driven by requests from technical advisors or coordinating partners. Understanding and interpretation of survey data was particularly challenging. Further capacity building of country-level staff may support the use of data for programmatic problem solving and to make implementation decisions.

Lesson 8: A vertical approach was effective, but integration will support long-term goals

Funds from these programmes took trachoma to a new scale of operation, allowing many districts to reach transition thresholds quickly through an efficient, vertical approach. Although a vertical approach was perceived to be appropriate initially, participants noted the increasing importance of integration with both eye care and the NTD sector as countries reach elimination thresholds.

"We need to do more about eye care. The vertical programme has a place [but] we are not doing enough about the broader eye care sector, not investing enough into the WaSH side and building up that system. Those results are not immediate." – Coordinating partner

How integration is operationalised across the NTD sector and with eye care has differed greatly by country, with insufficient evidence about what works best and in what contexts

Although opportunities for integration of trachoma elimination activities with other NTDs were somewhat limited, the general approach of planning and coordinating as an NTD unit was seen to be effective and efficient. Countries have different arrangements in terms of where trachoma sits and how it is managed, which has implications for integration. In countries where trachoma is in the NTD department and is overseen by a well-coordinated NTD task force, collaboration appeared to function well. Where trachoma is governed by an eye health care department, building collaboration between the eye and NTD departments was often resource- and time-intensive. Political realities often limited the ability of programmes to integrate. In one country, it was observed that trachoma elimination efforts would have progressed more quickly had trachoma been situated directly under the NTD programme instead the eye health unit.

Positive examples of integration exist along a continuum:

Ethiopia has made a concerted effort to integrate MDA for different NTDs, developing a national plan, a single drug distributor training curriculum covering all NTDs and piloting integrated training for MDAs. However, in practice, opportunities for integrating distribution were limited by calendar periods, the need to maintain standards and coverage for trachoma MDA, the impact of side effects from other drugs on subsequent drug acceptability and intensive drug distributor workload.

In Nigeria, collaboration with other NTDs facilitated implementation in insecure areas.

"Instead of integration, we currently have better coordination." – Federal Ministry of Health Representative, Ethiopia

NTD integration was also a key factor supporting F&E implementation,

particularly with regards to advocacy efforts around the inclusion of face washing in hygiene promotion interventions. In Ethiopia, an important success factor was the seconding of WaSH technical expertise into the NTD programme, as well as DFID forums for NTD-WaSH coordination.

"It makes sense to fit trachoma under NTD rather than under eye health due to complementarity with F&E."
– Global Technical Expert

More clarity and guidance are needed on what to integrate, how and when. Documentation of successful experiences integrating with other NTDs, as well as preferred practices to sustain meaningful integration, are needed, for example with regards to governance and accountability mechanisms.

"As trachoma is slated for elimination, some aspects of trachoma control do not need integration while others do – helping people to understand what should be integrated and what not can be very time consuming."
– Global Technical Expert

© Aurelie Marrier d'Unienville / The Queen Elizabeth Diamond Jubilee Trust

Lesson 9: Transition is a process, not an event

Elimination of trachoma as a public health problem is determined by WHO-established district-level prevalence thresholds (i.e. prevalence of Trachoma Follicular infection [TF] and prevalence of TT). When district prevalence of TT falls below the elimination threshold, dedicated case finding and outreach services can be discontinued. 'Transition' refers to the process of preparing districts to manage trichiasis cases within the routine health system following the WHO validation of elimination, shifting from a public health approach to a clinical approach. As MDA activities are scaled down, how sanitation and hygiene promotion interventions will be embedded in health and WaSH outreach programmes must also be clearly outlined; transitioning F&E elements is part of the strategic approach from the outset. Moreover, the F&E components require strong partnership to improve access to infrastructure, and a longer lead time to allow behaviours to change.

Transition planning for TT provides a valuable example of how the programmes gathered and applied learning along the way. Due to the rapid scale-up, many districts reached elimination thresholds quickly and the programmes needed to plan for transition when it was already happening. ICTC members developed a set of transition toolkits to support planning for this process, led by the grant manager. Toolkits covered planning for TT, MDA and F&E and built on early experiences to the benefit of those who began transitioning later. Learning shared during this exercise relates mostly to the TT toolkit, launched in 2019. Key lessons learned and identified good practices are described below.

Early planning from the start of an elimination programme

Long-term sustainability and transition should be discussed at the programme planning stage. Stakeholders at all levels need to know what transition planning means and entails. There must be adequate time to allow for proper transitioning so that districts do not feel as if they have been left behind. Some partners noted they were unprepared for the withdrawal of external funding as districts reached TT elimination thresholds.

Cultivating strong ownership of the transition process at national and sub-national levels

Where stakeholder involvement was high, transition was easier. Transition must be effectively triggered at the national level, with a strong recognition and communication that it is time to transition. The sub-national level can then take its cue from the national level. Malawi was one of the first countries to transition and demonstrated an effective leadership model (see page 33).

Approaches for cultivating ownership included involving stakeholders in multisectoral planning meetings and working through government structures at all levels.

"It all begins with collaboration. That harmony creates an environment to introduce meetings at the beginning where the District Health Management Teams are made aware that there will be a time when all services will be handed back to the district from the Implementing Partners. This way the district authorities feel that they are respected and that they own these programmes." – Implementing Partner

Regular communication and mentoring on the transition process

Clear and consistent communication throughout the programme, combined with on-the-ground mentoring, was important for both preparing the ground and sustaining support for the transition process. This was largely done through planning meetings at sub-national levels, involving technical and political leaders, F&E partners and those who would continue to offer services post-elimination. Key elements of strategic communication were:

- Sharing evidence from the programme to demonstrate the progress achieved, equip stakeholders with evidence regarding elimination, and acknowledge remaining needs.
- Reassuring the region/district health teams that the programme exit would not be a sudden event.
- Disseminating plans for continuity of services to walk-in patients post-elimination and handover of equipment and consumables for static centres chosen by the districts.
- Conducting 'transition messaging' during the final outreaches, leading to some refusals accepting surgery during the scale-down.
- Emphasising the importance of continuing F&E with support from the other actors: "That is where the gains will be sustained."

Malawi: Ministry of Health leadership was key to successful transition

Districts in Malawi reached TF and TT elimination thresholds in 2018, prompting the need to transition back to routine delivery of health services from the project outreach approach.

Key good practices included:

- Ministry of Health led process: The ministry triggered the transition process through a letter from the Chief of Health Services to all districts. Transition should not just be at district level and below; it must start at national level in terms of data and project management to facilitate a smooth transition at lower levels.
- Involvement of all stakeholders in transition planning, including district health management teams and the district WaSH teams.
- Microplanning revealed various gaps at district level that were addressed and which resulted in the programme achieving its targets. This process empowered districts in a way that prepared them for transition. Microplanning was encouraged for all SAFE components. Resources were provided for National Trachoma Task Force members to support the districts with the planning processes.

"Transition is a process, not an event. In places where we handle transition as a process it goes much better. When we have started the process in good time, we have an opportunity to work with the ministry and system until they are comfortable."

– Regional Technical Advisor

The ICTC transition planning toolkits provide non-prescriptive recommendations on the types of planning decisions requiring consideration and suggested activities to be undertaken. During early transition planning meetings in one country, district health workers expressed some reluctance to transition. Providing district level staff with an opportunity for creative thinking on how to ensure continuity of services facilitated engagement and support for the process.

Strengthening linkages with routine eye health care

For TT, the process of planning the location of static sites that will be supported post-elimination should start early. Linkages with these sites can then be established. In Tanzania, partners sought to establish static sites for trichiasis surgery earlier in the programme, in order to allow time to provide mentorship at the static sites while the same surgeon carried out surgery at other sites. Experience from Malawi, Uganda and Tanzania also highlighted the importance of transferring relevant equipment and consumables to the districts to support programme continuity. Some districts were reluctant to transition after reaching elimination thresholds due to health facilities' limited resources. Providing an initial supply of instruments and consumables helped facilitate the transition. Transitioning is still at the planning stage in many settings. Key challenges requiring continued attention include:

- **Budget allocation and release by ministries, especially to the sub-national level, requires time, advocacy and planning.** Some countries are still very much donor dependent with no domestic funding released for trachoma control.

  "One of the main challenges has been that the government (all levels) has never come up with funding to support the trachoma work. It's very donor dependent."
  – Coordinating Partner

"[Transition is] a discussion that needs to be started early and needs to recognise that districts and provinces have their own plans and budgets they need to make. The discussion was brought up last year, but it was too late to put any activities in workplans."
– Coordinating Partner

- **Uncertainty around government procurement of TT surgical equipment and consumables, long-term surgical skill retention, and mobility of patients referred from remote areas to static sites.** In some contexts, there is no existing eye health system that can manage identification and treatment of trichiasis cases.

  "The assumption is that the district will integrate into planning, but in most cases, it is very political. For example, the use of supplies and consumables: once the programme ends, it is expected the district will provide for those. But budgets are very limited, and districts have many things to handle."
  – Implementing Partner

- **In some countries, resistance by surgeons and NGOs to transitioning,** as this entails a loss of per diem and funding.

  "Scale-down is tough as we have to manage expectations of those partners who expected a longer-term engagement or who have come to rely on the large-scale to leverage their own input." – Ministry of Health Representative

- **The late kick-off of the F&E component and limited integration of F&E work into ongoing WaSH programmes caused delays in transition planning.** The concept of transition itself is not especially meaningful to the WaSH sector and communication might better focus on sustainability and doing good development. This difference in perspective may need further consideration in communication around transition planning with WaSH partners.

Lesson 10: Partnering adds value through extending programme reach and sharing learning

A common strategy and goal provide a crucial foundation for collaboration

This programme was built on a complex set of relationships between two donors, a multi-stakeholder coalition, ten health ministries and many NGOs. There was wide agreement that the success of this programme started at the top with the ICTC. Key factors enabling successful collaboration on this immense scale were:

- **A clear goal and strategy:**
  A shared vision and a clear roadmap for how to get there, strategically and operationally.

- **The involvement of long-term actors:**
  Most partners have been engaged in trachoma policy and implementation for a while, generating familiarity, trust and respect between partners.

- **Effective leadership and collegial personalities:**
  Strong personal relationships and mutual respect between leadership and other programme actors facilitated effective leadership.

- **The ICTC partnership model:**
  An inclusive coalition of actors deeply invested in doing trachoma work, willing to compromise to achieve a common aim rather than compete.

"They have really strong, clear leadership. Good support from the WHO. Clarity of vision from key organisations. There is an established strategy and goal, everyone's pulling in the same direction, the same way." – Donor

Leveraging partners' strengths and long-term relationships in-country

Partnership was widely perceived to add value to the programmes by extending reach (across and within countries), facilitating access to the best available technical expertise and enabling coordinated approaches for reaching cross-border populations. The coordinating partner mechanism in particular was viewed as a good practice, facilitating access to technical support and reducing the reporting burden for individual partners, allowing them to focus on delivering the programme. However, success varied according to the coordinating partner's level of engagement, resources, presence in the country and approach to the role (e.g. collaborative versus authoritative).

"Some partner headquarters have provided little support and supervision for their country offices while others have not given their in-country staff any say – both situations have limited in-country engagement." – Global Technical Expert

Some countries struggled to understand the different roles and how to maximise the benefits of each partner's contribution.
In one country, the coordinating partner was not an implementing partner, which added confusion in the early phase.

"While collaboration and partnerships were key to the programme achieving its objectives, understanding and implementation of this aspect of the programme varied greatly from country to country and sometimes even within countries."
– Global Technical Expert

The value and importance of respecting implementing partners longstanding relationships in the country was also noted, along with the advantages that brought in terms of in-country politics, geographical coverage, procurement processes and sustainability.

Shifting partnership culture from competition to collaboration in pursuit of a common goal

In some countries, the programmes made an important contribution to shifting the partnership culture from one of competition to collaboration. Health ministry leadership, a clear coordinating partner role, a common strategy and preferred practices, and opportunities for cross-learning and experience sharing were good practices enabling this change. Effective collaboration was frequently identified as a crucial factor for achieving programme results.

"One of the main successes has been this unique model of partnership itself, as it has allowed key stakeholders to work in collaboration and not competition any more. It has promoted a good work environment and partnership, planning together and sharing experiences." – Coordinating Partner

In countries where national leadership for trachoma was unclear, implementing partners sometimes remained protective. In these contexts, gaps in coordinating and communicating with a wide range of implementing partners sometimes limited achievements.

Promoting learning through regular, structured forums

In-country quarterly and annual stakeholder review meetings were of immense value for sharing learning and defining common strategic approaches across partners, including developing a shared understanding of the ICTC preferred practices and their adaptation and adoption. In most countries, these meetings were fully integrated with the National Trachoma Task Force.

"The good thing with this funding was mandating quarterly meetings. It does cost money if not based out of the capital to be able to afford a task force meeting. Having funding available to enable task force meetings […], being in the same room to be able to discuss issues… People learned from each other." – Coordinating Partner

The programme also supported other experience sharing forums. For example, in Uganda, surgeon review meetings were held to review progress against elimination targets, challenges and solutions. In Malawi and other countries, exchange visits were held between implementing partners. The programmes also utilised existing regional forums, such as the East Africa Regional Trachoma Meeting, to facilitate cross-border programme planning.

"Conducting learning meetings and visits among implementing partners was very effective. […] By promoting exchange visits partners learned and were able to share challenges and solutions objectively, based on a particular context. This was successful due to the use of ICTC preferred practices which was the basis of providing feedback." – Coordinating Partner

It was noted that there was an opportunity to augment the value of these forums by providing more space for implementation staff. Further opportunities to share experience and learning on a global level was also cited as an area for improvement.

"Creating space and budget for mid-level staff to attend meetings – that is really where you get cross-pollination and lessons shared."
– Coordinating Partner

© Rob Beechey / The Queen Elizabeth Diamond Jubilee Trust

SUMMARY OF KEY LESSONS

Trachoma elimination: the path towards success

With an unprecedented scale of financial support and a unique and effective partnership model, the programmes have made significant progress in eliminating trachoma in the areas in which they worked. This has been made possible by a common, coherent approach to delivery, facilitated by the ICTC's inclusive partnership model and led by health ministries at the country level.

The adoption of standardised guidance and ICTC preferred practices has been key to progress

Uptake has been facilitated by health ministry leadership, the best available technical assistance and forums for experience sharing. Across countries, there was wide evidence of buy-in for a multi-faceted quality assurance approach to improve surgical performance, with quality measures now seen as a key part of programme implementation. The introduction of systematic case finding approaches was a key transformation in reaching all those in need of trichiasis surgical services. A door-to-door approach, covering an entire administrative zone, was crucial for generating good data on coverage, and for ensuring that the most vulnerable TT patients were reached and given the opportunity to access services. ICTC preferred practices for ensuring high MDA coverage have been widely adopted and effective, with coverage reaching at least 80% of the target population in the vast majority of evaluation units. The programmes worked on delivering effective F&E interventions, developing new partnerships with the WaSH and education sectors and introducing strategic approaches to BCC implementation guided by technical expertise. Trachoma-related behaviours such as face washing have now been included in many national WaSH policies and strategies.

Strengthening of health systems was perceived to be an important achievement, with key building blocks put in place to support long-term health system integration in some contexts

Under the leadership of health ministries, the programmes conducted capacity building at all health systems levels, improved the use of data and information, and improved drug availability and management. The rapid scale-up allowed many districts to reach elimination thresholds quickly. ICTC transition toolkits were developed, and many districts have begun a transition process for one or several components of the SAFE strategy.

Partnering added value through extending programme reach and sharing learning

Successful collaboration was enabled by a clear goal and strategy, the involvement of long-term actors, effective leadership and the ICTC's inclusive partnership model. Partnership allowed the programmes to leverage partners' strengths and long-term relationships in country. Moreover, in some countries, the programmes were seen as having made an important contribution to shifting the partnership culture from one of competition to collaboration in pursuit of a common goal. Promoting learning through regular, structured forums supported implementation, adoption and adaptation of strategic approaches.

Future considerations

In order to sustain these gains and continue to support countries towards trachoma elimination, several strategic areas require continued attention going forward. Working groups within the ICTC and Neglected Tropical Disease NGO Network are currently addressing many of these challenges, including through the documentation of new ICTC preferred practices addressing many of these challenges, including through the documentation of new ICTC preferred practices.

Lessons for the delivery of the SAFE strategy

Strengthen environmental health, WaSH and NTD partnering. Through partnerships, continue to expand the quality and coverage of F&E interventions in all targeted areas based on evidence. Support uptake of the new toolkit, "WaSH and Health working together: a practical guide for NTD programmes", to develop and sustain meaningful intersectoral collaborations.

Develop tailored strategies, based on programme data and findings from operational research, to cover the hard-to-reach, in particular, nomadic populations and those living in less stable contexts.

Consider how best to address the needs of those who are blind or have severe visual impairment and can no longer benefit from trichiasis surgery.

Continue to invest in quarterly review meetings to further increase the uptake of ICTC preferred practices and enhance country ownership to continue this dialogue between all relevant ministries and stakeholders.

Continue to invest in country staff capacity building on the use of data for decision-making and reporting and increase accountability for making evidence-based decisions and following preferred practices.

Develop the evidence base to enhance behaviour change communication approaches, identify the most appropriate water and sanitation interventions and measure success.

Surgical preferred practices and guidelines should address opportunities for remote supportive supervision, the use of lower-level cadres as supportive supervisors and approaches for supporting three- to six-month post-op follow-up visits.

Future considerations

Lessons for successful transitions and sustainability

Appreciate that transition is a process, not an event. Transition requires early planning, ownership, clear communication and linkage with routine eye health care.

Acknowledge the success of an initial vertical approach, but recognise that integration – with the wider health sector (NTD programmes and routine eye health care), the WaSH and education sectors – **will require more attention going forward.**

Further support the development of equity-sensitive strategies as part of transition planning to ensure equitable service provision post-elimination (e.g. mobility, accessing static sites). Use existing evidence and learning on the best approaches to foster financial and policy-level support for equity-oriented eye care services.

Share learning and coordinate with other NTD programmes and communities for wider impact. Continue to identify opportunities and pilot approaches to improve NTD integration, coordination and alignment of NTD elimination programmes and interventions.

Consider additional strategies to maintain surgical capacity through health worker recruitment, professional development and retention.

Further document on-the-ground experience with systematic case finding, including examples of how to document case-finding efforts to support elimination dossier preparation for validation by the WHO.

Test and document strategies for maintaining quality assurance as programmes transition to routine eye health services.

THE QUEEN ELIZABETH
DIAMOND JUBILEE TRUST

Sightsavers

ICTC International Coalition
for Trachoma Control

UKaid
from the British people