

Technical resource



Trachoma Action Planning

A planning guide for the national elimination of blinding trachoma

ICTC International Coalition
for Trachoma Control

Acknowledgements

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Views represented in this manual are of the coalition and not necessarily the official views of individual member organizations or agencies.

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Front cover: A woman at a mass drug administration (MDA) in northern Mozambique plays with her baby while she waits to receive trachoma medicine donated by Pfizer. Photo: International Trachoma Initiative/Noah Kafumbe

Foreword

Countries, partners, and donors are committed to the global elimination of trachoma as a public health problem by 2020. Achieving this public health milestone requires more than funding; it requires health personnel with the right mix of skills, in addition to supported and well-managed health systems.

Effective and efficient planning for trachoma elimination is the critical first step. Planning brings together the right people, with the right information, at the right time to ensure that trachoma elimination is based upon sound evidence and consideration of the local context. As all endemic countries are dealing with a dynamic situation planning must be similarly dynamic.

Trachoma Action Planning (TAPs) started in 2011 after a call for development of a template for trachoma elimination planning at the 2010 meeting of the Alliance for GET2020. The TAP process starts with clarification of the goal: achievement of trachoma elimination, then works back from there to identify the activities needed to reach elimination. Thus, TAPs focus on setting aggressive but realistic targets and determining the steps required to make them possible.

In many trachoma endemic countries the TAP becomes the trachoma component of the NTD Master Plan, providing the level of detail necessary for meaningful intervention. Each year it is anticipated that TAPs will be reviewed, incorporating new data and new lessons learned; the outcome of these reviews will be supplements to the TAPs.

The purpose of this TAP manual is to provide a guide for how to conduct an effective and efficient TAP; it is not meant to be prescriptive. The agenda and related materials in this manual should be adapted based upon the local needs. Additionally, it should be recognized that undertaking a TAP and implementing a trachoma elimination plan require strong partnership between all stakeholders: national programme staff, NGOs, academics, and others. Preparing for a successful TAP takes time and all involved should start the planning process as soon as possible.

It is essential that those who use this manual also have access to other trachoma materials (**Box 1**). Finally, it is

BOX 1

Reference material manuals

The Global Scientific Meeting on Trachomatous Trichiasis

LSHTM trichiasis surgery DVD

WHO Trichiasis Surgery for Trachoma (yellow manual)

Planning for the elimination of trichiasis manual

Training of trainers for trichiasis surgery (includes use of Head Start)

Supervision guidelines for trichiasis surgery

List of TT instruments & consumables for a team plus the unit cost (or per 50 cases)

Monitoring outcome of trichiasis surgery (including standard form)

important to recognize that with ongoing improvements to WHO guidelines for elimination and dossier preparation, periodic revisions to components of the TAP process will be necessary.

We ask you to help us by letting us know about your ideas and experiences. Good luck!

With thanks,

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HKI Guinea staff and the Kissidougou district pharmacist stand in front of cartons of Zithromax®, donated by Pfizer to treat and prevent blinding trachoma. The medicine is stored in Kissidougou until the MDA begins. Then it will be moved again to the community that is endemic with trachoma. Photo: International Trachoma Initiative/Joanna Pritchard

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A man in rural Ethiopia blows a horn to call nearby residents to a local MDA, where they can receive free medicine to treat and prevent trachoma. Photo: Paul Courtright

1. Introduction to planning for trachoma elimination

The World Health Organization (WHO) has named the year 2020 as the global elimination date for blinding trachoma as a public health problem. Recent funding by multiple donors and the donation of Zithromax® by Pfizer, Inc. have made achieving this goal a real possibility, allowing for disease mapping, mass drug administration, trichiasis management, impact assessments and post-endemic surveillance. Resources, however, remain limited and time is short, highlighting the need for endemic countries to plan strategically for the way ahead to 2020.

The Trachoma Action Planning (TAP) process is a result of a recommendation of WHO's Alliance for the Global Elimination of Trachoma by 2020 (GET2020) meeting held in Geneva in 2011, recognizing the need for countries to chart their way to elimination. The primary goal of TAP workshops is to design a strategic, yet realistic, plan for eliminating blinding trachoma. The process of planning is data driven and addresses all four components of the SAFE strategy: **S** for surgery to correct trachomatous trichiasis; **A** for antibiotic to treat infection; **F** for facial cleanliness as a preventive measure against transmission; and **E** for environmental improvement particularly increasing access to safe water and improved sanitation.

Each TAP workshop is designed for five days, with the first two days dedicated to trichiasis management and the last three days focused on elimination of active trachoma through antibiotic distribution, facial cleanliness, and environmental improvements. In organizing the workshop, the participants of the trichiasis section will not necessarily all be the same as those invited to attend the **A**, **F**, and **E** section. The trichiasis management planning will require ophthalmic personnel while the remainder of the week will involve those engaged in MDA and those from the water, sanitation and hygiene (WASH) sector. Trachoma programme managers should attend the whole week.

The workshop should be participatory, relying heavily on group work to solve problems and make recommendations for the necessary actions to move the country toward its trachoma elimination goal. The resulting plan should clearly delineate what needs to be done, by whom, and by when. The trachoma action plan should be viewed as a living document that is periodically updated as new data become available, routine trichiasis management data and data on antibiotics, face washing,

and environmental improvements are compiled, and situations change and new threats and opportunities present themselves.

To achieve the GET2020 goal of eliminating trachoma as a public health problem will require strategic thinking and planning and this process will hopefully provide the needed assistance to do just this.

When to plan for trachoma elimination

Currently WHO uses the prevalence of the clinical sign: trachomatous inflammation - follicular (TF) in order to determine endemicity of active trachoma. If the TF prevalence in children age 1-9 years in a district is 10% or above, it is clear: interventions of AFE are required. If TF prevalence in children age 1-9 years is between 5-9.9%, one year of MDA plus F&E may be conducted followed by impact assessments. If surveys are being conducted for the first time in a trachoma suspected area and the findings are <5% TF, it is likely that trachoma does not constitute a public health problem and no specific interventions are needed. That said, if there have been some trachoma control efforts in the past, the WHO has declared the elimination of blinding trachoma to be equivalent to a prevalence of TF in children age 1-9 years to be less than 5% for two and a half years after the last round of MDA.

In some endemic districts the prevalence of TF may already be below 5% yet the prevalence of trachomatous trichiasis (TT) may be above 1 case per 1,000 population. While these settings do not require planning for antibiotics, facial cleanliness, and environmental improvement (**AFE** of SAFE strategy) they do require planning for surgeries related specifically to trichiasis elimination (**S** component of SAFE strategy).



A boy washes his face with water from a pump in rural Ethiopia. Facial cleanliness is crucial to the WHO-endorsed SAFE strategy to eliminate blinding trachoma. Photo: Pfizer/William Vazquez

2. Planning for elimination of blinding trachoma (trichiasis)

This section of the manual addresses planning for trichiasis elimination while the second section of the manual addresses planning for the elimination of active trachoma--ensuring that the prevalence of active trachoma is below the WHO threshold to eliminate the risk that a person will develop trichiasis.

Goals of the trichiasis planning exercise

The goals of the trichiasis planning exercise are as follows:

1. **Calculate, district by district, the number of trichiasis interventions needed** (so that the prevalence of trichiasis unknown to the health system can be reduced to less than 1 per 1,000 population). Sum these values to determine the national figure of interventions needed.
2. **Determine, district by district, how many trichiasis interventions are needed each year to reach the ultimate intervention goal** (the total number of trichiasis interventions needed). Sum these values to determine the number of interventions needed nationally each year over the period of the elimination plan.
3. **Determine the specific activities needed** (at national, regional, and district) level that will enable the plan to be achieved.

It is anticipated that by the end of the trichiasis planning exercise, there is broad agreement as to the targets and activities to be undertaken. It should be recognized that activities may vary between the districts, based upon the local context. Also, where evidence may be weak (primarily the case for mobilization and TT case finding strategies) the activities may include some operational research in order to identify effective and efficient practices (preferred practices).

WHO Guidelines for the Elimination of Trachomatous Trichiasis (TT)

When to plan for TT elimination

The WHO has defined the elimination of trachoma as a public health problem to be equivalent to a prevalence of less than 1 case of TT (unknown to the health system) per 1,000 population (0.1%) and prevalence of TF of less than 5% among children aged 1-9 years old. Planning for reducing the prevalence of TT requires surgical services,

while planning to reduce active disease includes antibiotic distribution, facial cleanliness, and environmental improvement (AFE). All countries that have at least one area with TT estimated to be above 1 per 1,000 population should have active plans for reducing the TT prevalence through surgical and other services, regardless of whether the area also needs AFE interventions. In areas where TT is below the threshold but active trachoma is above the threshold, effective mechanisms should be in place to enable any person presenting with trichiasis to receive services.

Data needed for TT planning

As stated earlier, planning is data driven. That is, in order to plan for TT elimination it is necessary to have good quality data. The goal is to establish a figure for the number of backlog TT cases in a district. This requires four different pieces of information: [1] the population of the district, [2] the prevalence of TT (generally in the age group 15+), [3] the proportion of the population age 15+, and [4] the number of people receiving TT surgeries or other TT management since the survey. In this guide we will adopt the most common way to estimate the backlog of TT in a district, as experience has shown that the method is consistent, practical, and sufficiently robust for the purpose of planning. The collection and compilation of this data should be done before the workshop begins.

Required Data:

1. District population: Use the most current available data. Generally, these are the figures included in the ITI Zithromax® application. During the years of intervention it is not recommended to correct for population growth or recalculate the TT burden.

2. Trichiasis prevalence: Most population-based surveys include assessment of TT in a sample of the population age 15 years and over. Also note the date of the population-based survey.

3. Proportion of the population aged 15+: Generating prevalence figures for the entire population requires consideration of the proportion of population age 15 and over. This will vary country to country and those involved in planning need to obtain the best estimate for calculation. There is always some variation in population census figures at the district level. Sometimes the variation can be large enough to lead to significant differences.

4. Number of people receiving TT management since the survey: Planners should note that often surgeons report the number of surgeries done rather than the number of people receiving surgery. If this is the case it may be necessary to adjust the number of interventions since the survey. The correct number is the number of **PEOPLE** managed for trichiasis and not the number of **EYES**.

Once the above data are available you can calculate the estimated TT surgery backlog.

The backlog = (population * TT prevalence * % population age ≥15) - the number of *people* receiving TT management since the survey.

The ultimate intervention goal (UIG) is the number of surgeries or other interventions needed to ensure that the prevalence of TT is below 1 per 1,000 in the total population. Thus:

TT UIG = TT backlog - the allowable number of people with TT.

The allowable number with TT = total population * 0.001.

While all countries experience population growth and aging of the population, evidence suggests that reduction in the prevalence of TF also reduces the risk that the adult population with scarring of the conjunctiva will progress to entropion and TT. Thus, it is not necessary to extrapolate expected population growth each year and recalculate the backlog figures every year.

Activities to carry out prior to the TT Elimination Planning Workshop

Planning for a workshop should be done carefully in order to ensure that the plan that emerges includes the necessary information to effectively reach elimination. Experience suggests that two months are needed prior to the workshop to compile the necessary information and data.

Planning for the workshop

There are a number of activities that should be done before conducting the TT elimination planning workshop. These include:

- 1. Identify all relevant participants and send invitations** (make sure that the expectations of the workshop are clearly spelled out). Ideally, the number of participants should not exceed 30.
 - Make sure that the participants include those involved in TT management (ophthalmologists, TT surgeon trainers, supervisors, procurement officers, NGO support personnel, etc.)
- 2. Identify the lead national planning person** (to whom all communication should be addressed)
- 3. Identify planning facilitators** (at least two)
- 4. Identify the writing team** (3-5 people who will be responsible for summarizing information during the TT planning session and assisting with the drafting of the TT elimination document at the end of the workshop). Members of the writing team should have good typing and word processing management skills. Communication needs to be initiated early to ensure that the writing team is fully prepared for their role and responsibilities.
- 5. Ensure that the writing team plus a couple other people have laptops to capture information.**
- 6. Compile information on TT in the country** (see below).
- 7. Pre-populate the TT Excel sheet with district names and population and mapping data** (see Annex A)

Documents to compile before the workshop

Data and documents should be compiled prior to the workshop. This will help ensure that the workshop participants do not waste time (trying to compile at the meeting) and to have a common and consistent starting point for planning.

The following documents are required:

- Existing national strategic plans on trachoma control (previous TAP with any updates)
- Existing TT surgeon training curricula (including supportive supervision guidelines, if available)
- Existing TT surgeon certification guidelines

The following data are important to compile:

- List of districts with a TT prevalence above 0.1% and their population
- Map showing districts and prevalence of TT (ideally from the trachoma atlas)
- TT prevalence data for surveyed districts (including year of survey and age group surveyed)
- TT prevalence data from impact assessments undertaken (including year of impact assessment and age group surveyed)
- Number and placement of TT surgeons and year trained or provided refresher training
- Number of TT surgeries done in each district in the years AFTER the baseline mapping of impact assessment was undertaken
- The annual productivity of individual surgeons (ideally for the year prior to the planning session)
- Number and location of TT surgery training facilities (trainers, trainees, etc.)

In the past, most information on TT interventions included only surgeries done, with no record of other interventions (epilation for those refusing surgery, etc.). Also, most information was collected on surgeries done (number of operated eyelids) rather than on people receiving an intervention. Planning for elimination focuses on people receiving interventions rather than eyes receiving interventions. Thus, in most settings there will be some level of disconnect between the data available and the data most useful. As countries move forward with their TT elimination plans (including recording and reporting people receiving TT management) these areas of disconnect should decrease.

Conducting a TT elimination planning workshop

This section includes a recommended approach to the TT Elimination Planning workshop. The teaching objectives of each section are included. Following this section is the agenda (**Annex B**) that matches the suggested schedule. The schedule and topics should serve as a guide, with each national TT planning workshop (and updates of TT planning) considering what has already been done; for example, in some settings it may not be necessary to include the working group session on the costing of TT surgery (described in session X), if this has been done already. Also, it may not be necessary for the group to do a SWOT (strengths, weaknesses, opportunities, threats) analysis (described in section Y) if a national situational analysis has already been conducted in the past few years. The recommended teaching procedures can be adapted as desired by the facilitators and only serve as a guide. Throughout the two day planning session for TT elimination the use of PowerPoint presentation is limited to only providing information to assist with planning. The annex includes a copy of the PowerPoint slides and the group session questions; these can also be downloaded from the ICTC website (<http://www.trachomacoalition.org/TAPplanning>).

Day 1

Session 1: Expectations

Session Summary: Participants attend workshops with a variety of expectations about the nature of the workshop and what they will gain from their participation. These expectations may be different from the intentions of the organizers and if not discussed at the beginning of the workshop may cause confusion, dissatisfaction and hinder the learning process. This and the following session provide an opportunity to identify those expectations and reconcile them if possible with the workshop objectives and if not possible address the reasons why the expectation(s) cannot be met.

Objectives:

1. To determine the expectations the participants have in attending the workshop and their learning needs in terms of training (and trachoma).
2. To establish a pattern of group work for the workshop.

Duration: 30 minutes

Materials: Flip chart paper and markers

Handouts: None

Training Procedure:

1. Divide the participants into 4-5 groups. Each group should develop a list of 3-4 expectations they have for the workshop. By expectations we mean what the participant hopes to learn or achieve by attending the workshop.
2. Ask each group to nominate a facilitator and a secretary.
3. After 10 minutes ask the participants to return to plenary.
4. Ask a group to present their work.
5. Ask the other groups if they had any different expectations; add these to the flip chart paper.
6. The facilitator should then advise the participants that the next session will include the objectives of the workshop and a comparison will be made between the expectations of the participants and the goals of the workshop.

Session 2: Norms

Session Summary: This session is to establish behaviours that the participants agree will be necessary to have a successful and productive workshop.

Objective: To set the ground rules for behaviours during the workshop.

Duration: 20 minutes

Materials: Flip chart paper and markers

Handouts: None

Training Procedure:

1. Ask the participants what norms are (behaviors/ rules that all agree on).
2. Brainstorm with the participants what they feel are the necessary norms for this to be a successful workshop (answers may include: not speaking at the same time, respect for others opinions, no side conversations; turn off cell phones, no smoking, etc.).
3. Write the responses on the flip chart.
4. Ensure that all participants are in agreement.
5. Post the flip chart on a wall of the training room to be referred to if needed.

Session 3. Introduction to SAFE (focus on TT)

Session Summary: This session provides the background of the SAFE strategy and how the TT planning is structured. Though most participants invited to a TAP will already be familiar with the four components, facilitators need to ensure that everyone has at least a minimum level of knowledge necessary to participate. It is an opportunity to begin introducing some of the terms commonly used in trachoma planning such as TT, the target age groups and how TT as a public health problem is defined. It will be important to show some images of TT. Elimination criteria are discussed in the following session.

Objectives:

1. To ensure all participants are familiar with the SAFE strategy.
2. To ensure all participants are familiar with trichomatous trichiasis (TT).
3. To ensure all participants are familiar with the age groups in which we measure TT: typically people aged >15 years old (sometimes > 40).
4. To ensure all participants are familiar with the prevalence thresholds used to define elimination of TT (< 1 TT case unknown to the health system per 1,000 population) -- in particular that thresholds are based on people, not eyes.

Duration: 25 minutes

Materials: Flip chart paper and markers (a presentation that includes a few photos of TT is helpful)

Handouts: None

Training Procedure:

1. Write the letters SAFE on the flip chart.
2. Ask the participants what it refers to, writing their responses down.
3. As each component is identified ask the participants to explain the importance within the context of trachoma control and elimination.
4. Ask the participants what the eye signs of trachoma are, noting the responses on the flip chart paper.
5. Though other signs such as TF, TI, TS, CO may be mentioned, inform the participants that for trichiasis planning the focus will be on TT only, as this sign is used to trigger action.
6. Ask the participants what the important age group is for TT (> 15 years old though sometimes older data may indicate >40 years of age (not commonly done at this point in time).
7. Explain to the participants that these concepts will be critical for the work they are being asked to do and further essential information will be forthcoming in the next session.

Day 1 (continued)

Session 4: Introduction of the TAP Template, Objectives and Process

Session Summary: This session provides the participants with an overview of the Trachoma Action Planning (TAP) process and the objectives of the process. Also important in this session will be presenting the elimination targets for TT.

Objectives:

1. To introduce the overall principle of Trachoma Action Planning.
2. To present the overall objectives of engaging in this process.
3. To ensure all participants are familiar with the elimination criteria for TT.

Duration: 15 minutes

Materials: Flip chart paper and markers; slide with expected results of TT action planning within the TAP

Handouts: None

Training Procedure:

1. Explain that the Trachoma Action Planning process was developed to assist countries to strategically plan how to reach GET2020 goals, setting targets for each year remaining until 2020 or the elimination target date set by the country.
2. Show the slide with the expected results of a TAP (Annex C).
3. Ask the participants what the WHO target is for TT (less than 0.1% TT unknown to the health system in the total population); if there is some confusion, write the responses on flip chart paper.
4. Inform the participants that these two days will focus on TT and reducing the national backlog to the elimination level.
5. Also mention that many of the participants are there just for the TT section and different participants will be involved in the last three days of the week to plan for the A,F,E.
6. Explain that the TT elimination planning process starts with the target elimination year and works backwards against the backlog.
7. Write the letters UIG on the flip chart and ask the participants what this stands for (Ultimate Intervention Goal) and what it means (the total number of surgeries that need to be completed in order to achieve the WHO elimination target for TT) .
8. Ask the participants if the total backlog = the UIG. (It doesn't as we only need to reduce the # of cases to less than 1/1000 unknown to the health system).
9. Write the letters AIO and ask the participants what this stands for (Annual Intervention Objective) and what it means (the number of surgeries or other interventions that need to be done each year to reach the UIG by the target elimination year).
10. Ask the participants what is included in "other interventions". The focus of this discussion will be on epilation and counseling of people who refuse surgery. The goal is to get the participants to understand that they must plan for these "other interventions" as some patients, no matter how effective the programme is, will refuse surgery. These cases must be managed and their management must be recorded.
11. Ask the participants what factors must be considered in planning for reduction of the backlog to WHO threshold levels, writing the responses on the flip chart paper. These will include: # of TT surgeons; the distribution of those surgeons throughout endemic districts of the country; the average # of surgeries or other interventions each individual surgeon performs; the number of outreach services conducted; the supervision each surgeon receives.

Session 5a. WHO guidelines for TT programme implementation and elimination

Session Summary: This session reviews current WHO guidelines for implementation of trichiasis programmes as well as guidelines for elimination. The session also provides information on information collected on TT surveys. As guidelines evolve it is likely that the details in the presentation will need to be revised.

Objectives:

1. To provide WHO guidelines regarding programme implementation and elimination.
2. To provide information on the assumptions behind estimates of TT used for planning.

Duration: 20 minutes

Materials: Computer and projector; presentation on WHO guidelines

Handouts: None

Training Procedure:

1. Present the WHO guidelines (**see Annex D for presentation**).
2. The facilitator should also confirm that the participants understand the implications of the difference between TT measured during surveys and TT for surgical management. The facilitator should also address the definition of a TT case “unknown to the health system”.



Health officials in Mozambique participate in a workshop to create a Trachoma Action Plan for their country. Photo: International Trachoma Initiative/ Chantal Veira

Day 1 (continued)

Session 5b. Overview of TT and preferred practices for TT surgical service delivery

Session Summary: This session presents the current knowledge of TT, looking at the management of the condition, the training of surgeons and quality assurance, and increasing the surgical output and uptake. This presentation is a result of the Global Scientific Meeting held in Moshi, Tanzania in January 2012 and sets the stage for planning at the national level. The focus of the session is on preferred practices that need to be considered during planning for TT elimination. Also this session should introduce the concept of “case management,” recognizing that surgery may not always be the best alternative and that if people refuse surgery, alternatives such as epilation should be offered.

Objectives:

1. To provide the global context in which national planning will take place.
2. To introduce the current research concerning case management of TT, recognizing epilation is one component.
3. To introduce the current research concerning quality of surgery and the role of surgeon training.
4. To introduce the current research concerning increasing quantity of surgeries (surgical productivity) in order to reach 2020 goals.
5. Create understanding of reporting that includes surgeries, epilation, recurrences, planned surgeries and (informed) refusals (“patients known to the health system”).

Duration: 35 minutes

Materials: Computer and projector; presentation on the results of the Moshi meeting and more recent research findings

Handouts: Participants should be given a copy of the Moshi TT scientific meeting report

Training Procedure:

1. Present the findings from the Moshi meeting (**see Annex E for presentation**);
2. The facilitator should use this time to assess the knowledge and critical thinking of the participants by asking questions concerning the three main topics of the presentation (management, quality and quantity) and their applicability to the local situation.
3. Initiate a discussion regarding participants’ feelings about epilation as an alternative to surgery under certain conditions.

Session 6. National TT Situation: Evidence for Planning

Session Summary: This session provides the participants with an overview of the current situation of active trachoma and TT in the country. Focus on the prevalence of TT in the various endemic districts and regions. Any data from recent mapping and/or impact studies should be presented here as well as plans for upcoming mapping and impact studies. This presentation should be given by the national trachoma or NTD coordinator.

Objective: To provide the overall epidemiological context of the national TT situation in which the TT planning will take place.

Duration: 45 minutes

Materials: Computer and projector; presentation on the TT situation in the country

Handouts: None

Training Procedure:

1. The presenter prefaces the presentation by emphasizing that all strategic decisions should be based on the available evidence.
2. During the presentation, the presenter should encourage the participants to contribute and to question the data.
3. The presentation should conclude with concurrence on key findings and decisions by all participants. Note: one point that often arises is the denominator used to determine burden. National population figures are at times disputed by provincial/district authorities particularly if census data are old, but it is important that a common figure is used. Secondly, TT data are collected on people age 15+, while elimination is based upon the total population.

Session 7. Resources for TT interventions (human resources, infrastructure, instruments, consumables)

Session Summary: One of the key elements of a TT intervention strategy is having a well-trained human resource base focused on quality of surgery, high productivity and cost-efficiency in order to reduce the backlog in accordance with the national elimination goal. This includes not only the TT surgeons but also their supervisors and their trainers. This session provides the participants with an updated look at: national policies governing TT surgery; the number of surgeons (and who they are) currently practicing; the approach used to train the surgeons and provide refresher training; who the trainers are and training they have received as trainers; where the surgeons are located and how their distribution reflects the burden of TT; system of supervision; training supervisors receive; the productivity of the surgeons; the manner of service delivery (static vs. outreach services and campaigns); other relevant information as pertains to the national situation. This presentation needs to be prepared by the national trachoma or NTD coordinator in advance of the meeting. If the latter, coordination with the national eye care program will be needed. The presentation should be limited to 30 minutes to allow ample time for discussion.

Objectives:

1. To provide the participants with an overview of the current human resource base in the country.
2. To provide the participants with an understanding of the current productivity of TT surgeons in the country.
3. To provide the foundation for ensuing discussions on training, supervision and quality of surgery.

Duration: 45 minutes

Materials: Computer and projector; presentation on the TT human resource situation in the country

Handouts: None

Training Procedure:

1. During the course of the presentation, the presenter should seek agreement or differing opinions from the participants on the content.
2. Differing opinions should be noted on the flip chart to discuss further following the presentation.
3. Note that there will be group work on Day 2 that also will provide additional opportunity for discussion.

Day 1 (continued)

Session 8: Calculating the UIGs and AIOs

Session Summary: The Ultimate Intervention Goal (UIG) is the total number of people to receive surgery or other interventions to reach the WHO threshold of elimination while the Annual Intervention Objective (AIOs) define the number of people that are to receive a service each year in order to reach the UIG. This session divides participants into groups preferably by region to calculate each endemic district's UIG and the AIOs that will be necessary between now and the target elimination date.

Objectives:

1. To calculate the number of surgeries that need to be performed between now and the target elimination date. Also, to understand that there can be significant variations (large confidence intervals) around the TT prevalence figures, which means there can be considerable variation around the estimate of the TT backlog.
2. Understand that UIG is based upon the total population while TT prevalence data are generally collected on people age 15+ (and calculations are needed to reach the UIG).
3. To provide a model for the participants and national program to use in updating the calculations on an annual basis based on results of the previous year.
4. To identify if prioritization of districts can be undertaken; that is, do 4-6 districts account for a large proportion of the total TT cases in the country? If this is the case, the participants need to recognize the need for prioritization.

Duration: 1 hour 30 minutes (45 minutes for group work and 45 minutes for reporting back)

Materials: Computers, memory sticks with data sheet

Handouts: Data sheet

Training Procedure:

1. Ask the participants how to calculate the backlog and the UIGs. (The TT backlog is calculated by multiplying the prevalence of TT in the district by the district population and then multiplying that number by the national estimate of the proportion of the district population estimated to be > 15 years old. (Generally between 50% and 56% of the population is aged 15+.) (The UIG is calculated by subtracting 0.1% of the total population from the TT backlog). i.e. $UIG = TT \text{ Backlog} - (\text{Total population} \times 0.001)$
2. Take a sample district and calculate the backlog and the UIG as a group.
3. Ask the participants how they would then calculate these AIOs, leading them in a brainstorming session on what considerations need to be made so that the AIOs for each district are feasible to achieve. These considerations could include: # of surgeons currently working in the district; their level of productivity; the training of surgeons that would need to happen, etc. List these considerations on the flip chart paper. (Important here is to remind them that calculating the AIOs requires more than just dividing the UIG by the number of years remaining to the national elimination date).
4. Divide the participants into groups of 4-5. If the composition of the group allows, divide them according to region.
5. Ensure that all groups have a computer with the data sheet for the country uploaded on it.
6. Instruct the groups to make the calculations for the backlog, the UIGs and the AIOs and if appropriate prioritize the districts. Inform each group they will need to present their work, particularly on the decisions made for AIOs and prioritization.
7. The facilitators should circulate among the groups to ensure everyone understands the calculations.
8. Following the group work, ask groups to present their work, again focusing on the AIOs and their justification for how they plan to scale up and for prioritizing districts.

Session 9: Strengths, Weaknesses, Opportunities, Threats

Session Summary: Thus far the workshop has identified all the human resource base available as well as how the surgeons are trained, supervised, etc. The magnitude of the problem has also been identified through calculating the backlog, UIGs and AIOs. This session then looks at the overall situation considering the strengths and weaknesses and the opportunities and threats in all of the endemic districts. To save time, one group can list the strengths, one group list the weaknesses, one group list the opportunities and one group list the threats to achieving elimination of trichiasis throughout the country.

Objective: To get all participants to identify the major strengths, weaknesses, opportunities, and threats related to current trichiasis management in the country.

Duration: 1 hour 45 minutes (1 hours group work, 45 minutes presentation)

Materials: Flip chart and paper or computer and projector

Handouts: None

Training Procedure:

1. Ensure that the participants know what a SWOT is, answering any questions that may arise.
2. Divide the participants into groups of 5-6 ensuring that each group has a computer to record the discussions on or flip chart paper and markers.
3. Ask each group to identify 3-4 points for each of the 4 components of a SWOT (you may want two groups to focus on strengths and weaknesses and two groups to focus on opportunities and threats).
4. After an hour and fifteen minutes reconvene the group.
5. Ask the groups to present their findings. Following each presentation, invite comments, questions, and discussion.
6. After the last group's presentation, the facilitator should identify the common themes and areas where the group is in agreement and where more discussion might be needed.



A health worker in Ethiopia checks her records to find information on a person attending a mass drug administration for trachoma. Photo: Paul Courtright

Day 2

Session 1: Recap of Day 1

Session Summary: This session reviews the work of the previous day to make sure that all the participants are clear and in agreement with the calculations made and the analysis of the situation. The session is also designed to set the stage for the group work later on in the day looking at the next steps to be taken. Thus, either before or during this recap it is critical that there be overall agreement of the basic strategies that will be used to provide TT surgery. For example, it is hoped that the participants appreciate that training 2 TT surgeons per district does not make sense given the TT burden in the country. Similarly, it is expected that participants will recognize that conducting outreach will be necessary to reach their UIGs.

Objectives:

1. To review the previous day's work.
2. To confirm specific strategies needed to reach UIGs.
- 3 To begin discussing the next steps forward for the national program.

Duration: 30 minutes

Materials: None

Handouts: None

Training Procedure:

1. Ask the participants to comment on what they felt was the most important aspect of the work from the day before.
2. Ask if they have any questions on the work.
3. Ask the participants what they feel the next steps need to be in order to achieve GET2020 goals.

Session 2: Moving TT Elimination Forward

Session Summary: This session is structured as group work, with each group assigned a separate topic. The topics suggested here include the key aspects of a national TT strategy: training, supportive supervision, productivity, partnership, and costs of surgery. The results of the group work will then be turned into results-oriented activities.

Objectives:

1. To provide the opportunity for the participants to strategically think through the various next steps the national program needs to take given the SWOT conducted the day before.
2. To translate the strategic decisions into action points.

Duration: 3 hours (1.5 hours group work; 1.5 hours for presentation and discussion)

Materials: Computer and projector to review the questions, flip chart paper and markers

Handouts: Questions for each group to address (questions are included in **Annex F**; they may be adjusted according to national situation and need). The questions under each of the working groups are suggestions and may require some revision based upon the local context.

Training Procedure:

1. Present the various topics and the set of questions each group will be responsible for.
2. Divide the participants in 5 groups. Ideally, the groups should be self-selecting based on participant's interest and by recognized areas of expertise. It may be necessary, however, to request some participants to join other groups so as to have roughly equal numbers in each group.
3. Distribute the list of questions to each respective group.
4. Ensure that each group has a recorder, a laptop or flip chart paper, and markers.
5. Inform the groups that they have 90 minutes each for group work and for all presentations and discussion.
6. Remind the groups that they should use available evidence (discussed the previous day) and that to achieve good quality, productivity must be improved, and if productivity is to be improved, outreach must be included; just training and equipping more surgeons will not address the problem.
7. Inform the participants that the results of their discussions should be phrased as actions.
8. Inform the groups they may add any additional questions they feel are pertinent.
9. The facilitators should circulate among the groups to answer any questions and to help direct the discussion as needed.
10. After 1.5 hours, or when all groups have finished before then, reconvene the participants.
11. Ask the first group to present.
12. Conduct a discussion following each presentation to discuss the various conclusions seeking concurrence. If there are disagreements pursue those if time. If time is limited then write the issues in dispute on flip chart paper so that the national coordinator will have a record of outstanding issues.

Day 2 (continued)

Session 3: Next steps

Session Summary: This session defines the actions needed based on the responses to the questions in the previous session. People must be assigned to take responsibility for the various actions and a time frame must be provided for completion of actions. Given the technical nature of some of the activities and strategies, it is likely that there will be the need for a trichiasis working group to address specific issues (e.g., harmonization of training, certification, recording and reporting, monitoring outcome).

Objective: To ensure that the actions decided upon are carried out by appointing a lead person for each and a time by which it should be completed.

Duration: 1 hour

Materials: Flip chart paper, markers

Handouts: None

Training Procedure:

This session is led by the facilitator.

1. Going group by group, sum up the various actions identified previously; create a 3 column table on the flip chart. Record each action item in column one.
2. Ask the participants who would be best positioned to ensure that action takes place. Each action should have one lead person. Record the name next to the action in column two.
3. Determine when this action should happen; record the deadline on the paper.
4. Once all the actions have an assigned point person and time frame, the facilitator provides a summary of the past day and a half asking for any comments from the participants.

Follow up activities

Following the completion of the TT-planning workshop, a number of tasks need to be done. These include:

- Submission of the plan to all of the participants at the planning meeting so any final input can be obtained prior to completion.
- Merging the TT elimination plan with the rest of the trachoma elimination plan (that may be underway over the following three days).
- Convening of a small working group to deal with key nationwide issues such as procurement, training, certification, adaption and adoption of preferred practice manuals, etc.
- Drafting of estimated budgets (note that planning is by person while budgeting is by eye). Also, make sure that all forms of TT management, including the purchase of epilation forceps for people refusing surgery, are included in the budget.



Medicine donated by Pfizer is distributed at a school in Uganda to students, parents and children who live near the school.
Photo: International Trachoma Initiative/Elizabeth Kurylo



Women often walk great distances to collect their daily supply of water from a community pump.
Photo: Paul Courtright

Planning for elimination of active trachoma

This section of the manual addresses planning for elimination of active trachoma while the first section of the manual addressed planning for the elimination of TT.

Goals of the active trachoma elimination planning workshop

The goals of the active trachoma elimination planning exercise are as follows:

- 1. Calculate, district by district, the number of people who will need AFE** (antibiotics, facial cleanliness, environmental improvement) interventions and for what period.
- 2. Determine district-by-district how many people are to receive AFE each year as per guidelines.**
- 3. Determine when impact assessments and surveillance surveys are required.**
- 4. Determine the specific AFE activities needed** (at national, regional, and district) level that will enable the plan to be achieved.
- 5. Assess the elimination programme resource needs and gaps** (resource mapping).

It is anticipated that, by the end of the active trachoma elimination planning exercise, there is broad agreement as to the targets and activities to be undertaken. Activities might vary between the districts, based upon the local context. Also, where evidence may be lacking (often related to reasons for poor antibiotic coverage) the activities may include some operational and formative research in order to define approaches for hygiene and sanitation and identify effective and efficient practices (preferred practices).

Data needed for planning

Planning is data driven. In order to plan for the elimination of trachoma it is necessary to have data, from population-based surveys, on the prevalence of TF in children age 1-9 years. Prevalence of TF is measured in children, but interventions, including MDA, facial cleanliness interventions, and environmental improvement, are targeted to the entire population. Thus, census information is critical for planning. There is always some variation in population census figures at the district level; however, it is critical that efforts be made to establish

the most accurate figures in order to plan for antibiotic distribution properly.

The ultimate intervention goal for antibiotic distribution is the total number of people to be treated in all districts between now and the elimination target. The annual intervention objective is the annual number of people receiving treatment, recognizing that some districts may require three years of antibiotic treatment, some districts require at least five years of antibiotic treatment, and some districts may only be treated for one year.

All trachoma endemic countries are experiencing population growth which means that the number of people to be treated will increase year upon year. Planners should obtain national population growth figures to extrapolate population needs for the period under treatment. To plan for F&E interventions, data on water and sanitation coverage and current status of hygiene education should also be compiled.

Activities to carry out prior to the active Trachoma Elimination Planning workshop

Planning for a workshop should be done carefully in order to ensure that the plan that emerges includes the necessary information to effectively reach elimination. Experience suggests that two months are needed prior to the workshop to compile the necessary information and data.

Planning for the workshop

There are a number of activities that should be carried out prior to holding the active trachoma elimination planning workshop. These include:

- 1. Identify the participants and send invitations**, making sure that the expectations of the workshop are clear. Ideally, the number of participants should not exceed 30.
- 2. Make sure that the participants include those involved in AFE** (district health officials, district water and sanitation officials, supervisors, supply chain managers, NGO support personnel, WASH NGOs, health promotion unit, Central Medical Stores, etc.)

3. Identify the lead national planning person (to whom all communication should be addressed).

4. Identify planning facilitators (at least two).

5. Identify the writing team (3-5 people who will be responsible for summarizing information during the trachoma planning session and assisting with the drafting of the trachoma elimination document at the end of the workshop). Members of the writing team should have good keyboarding skills. Communication needs to be initiated early to ensure that the writing team is fully prepared for its role and responsibilities.

6. Ensure that the writing team has laptops to capture information.

7. Compile information on trachoma and WASH at the district level in the country (see below).

8. Pre-populate the TF and MDA Excel sheet with district names and population and mapping data (see Annex G). This data may be transferred from other existing databases or sources.

9. Pre-populate the F&E partners sheet (see Annex H).

10. Conduct full F&E situation analysis (Annex N).

Of particular note is the need to engage WASH stakeholders in this workshop. To make sure the right people are in the room in terms of decision making power and organisational remit, try to make it easier for them to see how attending a 3-day workshop on trachoma aligns with their own objectives. This is addressed in the guiding principles, but keep the following points in mind:

- Trachoma affects the poorest and most marginalised communities, and leads to poverty and disability – working on this issue together can help us ensure that these communities gain access to the services they need, and address issues of equity and inclusion
- Working on trachoma can help improve the public health outcomes of WASH services

Not all dialogue may seem immediately relevant to the WASH community, but their participation is important because elimination of active trachoma will not be possible without full implementation of F&E activities. It will be important to frame the thinking of the WASH community about each session in terms of “how does this relate to my goals/what are opportunities for mutual gains?”

Data to compile before the workshop

Compile both data and documents prior to the workshop. This will help ensure that the workshop participants do not waste time (trying to compile at the meeting) and it supports a common and consistent starting point for planning.

The following documents are required:

- Existing national strategic plans on trachoma control (previous TAP with any updates)
- Existing NTD master plans
- Existing plans within the Ministries of Education related to school health
- Existing plans within Ministries of Water and/or Sanitation related to hygiene and sanitation plans. This should include:
 - WASH sector institutional structure
 - Sector/districts plans and programmes
 - WASH policy framework
 - Sector agencies (bilateral, multilateral, NGOs) and coordinating structure
 - National WASH networks
 - Existing hygiene/BCC programmes and events
 - NTDs/Trachoma communication and advocacy plans

Compile the following data:

- List of districts and their population and map(s) showing districts
- TF data for surveyed districts (including year of survey)
- TF data from impact assessments
- Plans for baseline mapping, impact assessments & surveillance
- Information on sanitation and water coverage by district (if possible)

Data on MDA

- MDA undertaken in each of the districts (year by year, from start of MDA) showing coverage

Data on F&E interventions

- Reports on specific face washing and environmental improvements activities
- Information on “clean face” prevalence (if available)
- ICTC F&E situation analysis

Ministries of Health that are currently involved in Zithromax® MDA with donated drug from Pfizer through the International Trachoma Initiative already have a good system for managing the population figures and coverage. The availability of data on F&E is more problematic. The Global Trachoma Mapping Project (GTMP) has some F&E data at the district level, some of which may be useful for planning purposes. Most countries have data that include measures of latrine coverage, however these findings do not always correlate well with GTMP or other data. Planning for AFE must include participants from the WASH sector (and donors) who can identify and compile the available information, as well as attend the three days of the AFE section.

Conducting an active trachoma elimination planning workshop

The following section includes a recommended approach to the active trachoma elimination planning workshop. The teaching objectives of each section are included. Following this section is the agenda (**Annex I**) that matches the suggested schedule. Each national active trachoma elimination planning workshop (and updates of trachoma planning) should consider the context; for example, in some settings it may not be necessary to include the working group session on the costing of antibiotic distribution, if this has been done already. Also, it may not be necessary for the group to do a SWOT analysis if a national situational analysis has already been conducted. The questions under each of the working group sessions are suggestions and may require some revision based upon the local context. The recommended teaching procedures can be adapted as desired by the facilitators and only serve as a guide. Throughout the three-day planning for active trachoma elimination, the use of PowerPoint presentation is limited to only providing information to assist with planning. The annex includes a copy of the PowerPoint slides and the questions; these can also be downloaded from the ICTC website (www.trachomacoalition.org/TAPplanning).

Day 1

Session 1: Expectations

Session Summary: Participants attend workshops with a variety of expectations about the nature of the workshop and what they will gain from their participation. These expectations may be different from the intentions of the organizers and if not discussed at the beginning of the workshop may cause confusion, dissatisfaction and hinder the learning process. This and the following session provide an opportunity to identify those expectations and reconcile them if possible with the workshop objectives, and if not possible to address the reasons why the expectation(s) cannot be met.

Objectives:

1. To determine the expectations the participants have in attending the workshop and their learning needs in terms of training (and trachoma).
2. To establish a pattern of group work for the workshop.

Duration: 30 minutes

Materials: Flip chart paper and markers

Handouts: None

Training Procedure:

This session is led by the facilitator.

1. Divide the participants into 4-5 groups and as a group develop a list of 3-4 expectations they have for the workshop. By expectations we mean what the participant hopes to learn or achieve by attending the workshop.
2. Ask each group to nominate a facilitator and a secretary.
3. After 10 minutes ask the participants to return to plenary.
4. Ask a group to present their work.
6. Ask the other groups if they had any different expectations and write them on flip chart paper.
6. The facilitator should then advise the participants that the next session will include the objectives of the workshop and a comparison will be made between the expectations of the participants and the intention of the workshop.



ITI Director Paul Emerson (in sunglasses) looks for signs of trachoma in the eyes of a man in Ethiopia. Photo: Pfizer/William Vazquez

Day 1 (continued)

Session 2: Norms

Session Summary: This session is to establish behaviours that the participants agree will be necessary to have a successful and productive workshop.

Objective: To set the ground rules for behaviours during the workshop.

Duration: 20 minutes

Materials: Flip chart paper and markers

Handouts: None

Training Procedure:

1. Ask participants what norms are (behaviors/rules that all agree on).
2. Brainstorm with participants what they feel are the necessary norms for this to be a successful workshop (answers may include: not speaking at the same time, respect for others opinions, no side conversations; turn off/put on silent or airplane mode cell phones, no smoking, etc.).
3. Write the responses on the flip chart.
4. Ensure that all participants are in agreement.
5. Post the flip chart on a wall of the training room to be referred to if needed.

Session 3: Introduction to SAFE (focus on antibiotics, facial cleanliness, environmental improvement)

Session Summary: This session provides the background of the SAFE strategy and how the AFE planning is structured. Though most participants invited to a TAP will already be familiar with the four components of the SAFE strategy, facilitators need to ensure that everyone has at least a minimum level of knowledge necessary to participate. It is an opportunity to begin introducing some of the terms commonly used in trachoma planning such as elimination, surveillance, the target age groups and how a public health problem is defined. It will be important to show some images of TF.

Objectives:

1. To ensure all participants are familiar with the SAFE strategy.
2. To ensure all participants are familiar with trichomatous inflammation - follicular (TF).
3. To ensure all participants are familiar with the age group in which we estimate TF prevalence: age 1-9 years.
4. To ensure all participants are familiar with the prevalence rate thresholds used to define elimination of trachoma (<5% TF in children age 1-9 years).

Duration: 25 minutes

Materials: Flip chart paper and markers (a presentation that includes a few photos of trichiasis or a short video clip is helpful)

Handouts: None

Training Procedure:

1. Write the letters SAFE on the flip chart.
2. Ask participants what it refers to and write their responses down.
3. As each component is identified ask the participants to explain the importance within the context of trachoma control and elimination.
4. Ask the participants what the eye signs of trachoma are, noting the responses on the flip chart paper.
5. Though other signs such as TT, TI, TS, CO may be mentioned, inform the participants that for trachoma planning the focus will be on TF only, as this sign is used to trigger action.
6. Ask the participants what the important age group is for TF (age 1-9 years).
7. Explain to the participants that these concepts will be critical for the work they are being asked to do and further essential information will be forthcoming in the next session.

It should be noted that not all of the WASH stakeholders will be familiar with trachoma. According to the participants present, it may be useful to dedicate a few minutes to discuss this, as well as the broader benefits of working on trachoma for equity, poverty reduction, and general public health.

Day 1 (continued)

Session 4: Introduction of the TAP Template, Objectives and Process

Session Summary: This session provides the participants with an overview of the Trachoma Action Planning (TAP) process and the objectives of the process. Also important in this session will be presenting the trachoma elimination targets for AFE.

Objectives:

1. To introduce the overall principle of Trachoma Action Planning.
2. To present the overall objectives of engaging in this process.
3. To ensure all participants are familiar with the elimination criteria for TF.

Duration: 15 minutes

Materials: Flip chart paper and markers; slide with expected results of trichiasis action planning within the TAP

Handouts: None

Training Procedure:

1. Explain that the TAP process was developed to assist countries to strategically plan how to reach GET2020 goals, setting targets for each year remaining until 2020 or the elimination target date set by the country.
2. Show the slide with the expected results of a TAP (**Annex C**).
3. Ask the participants what the WHO targets are for TF; if there is some confusion, write the responses on flip chart paper. (Less than 5% TF in children age 1-9 years).
4. Inform the participants that these three days will focus on reducing TF prevalence by AFE interventions.
5. Explain that the planning process starts with the prevalence data, assigning the first year of AFE, subsequent years of AFE, impact assessment, then surveillance (which includes continued F&E).
6. Write the letters UIG on the flip chart and ask the participants what this stands for (Ultimate Intervention Goal) and what it means (the total number of people needing AFE intervention in order to achieve the WHO elimination target for TF).
7. Write the letters AIO, again asking the participants what this stands for (Annual Intervention Objective) and what it means (the number of people receiving AFE interventions each year).

Session 5. Review of TT Plan

Session Summary: As SAFE is an integrated strategy, it is important that those who did not participate in the first two days of the workshop know what the outcome of those days were. This provides a fuller context to the national plan. Ask a participant who was present the first two days to give the presentation.

Objective: To inform the participants for AFE of the process and results of the first two days of the meeting that discussed TT.

Duration: 15 minutes

Materials: Projector and laptop; summary presentation from Days 1 and 2

Handouts: None

Training Procedure:

1. Present the process and results of the first two days to the participants.
2. Indicate how the process of those two days will be similar as to the next three days.
3. Ask for and respond to any questions the participants might have.

Session 6. Current national situation regarding mass drug administration and coverage

Session Summary: This session briefly reviews the evidence needed in making decisions for achieving GET2020 goals. Second, this session is designed to provide the participants with an overview of the current national situation in terms of antibiotic distribution. The presentation should include for A: # of endemic districts; # districts receiving drugs (# for 3 years and # for five years); coverage achieved; # of districts having conducted impact studies; # ready or near ready for impact studies, etc.

Objectives:

1. To review the data necessary for planning the elimination of blinding trachoma.
2. If needed, review where the country is in the process of collecting/compiling this data (and where mapping may be needed).
3. To ensure that all participants are familiar with WHO criteria for determining when districts are trachoma-endemic, when to start AFE and stop, and when additional surveys are needed.
4. To inform the participants of current global efforts in mapping.
5. To provide the overall context for trachoma action planning.
6. To present the current and historical situation of Zithromax® distribution in the country.

Duration: 30 minutes

Materials: None

Handouts: None

Training Procedure:

1. Ask the participants what data is necessary for evidence-based planning for A (TF prevalence at the district level, # years of MDA and coverage achieved).
2. Ask the participants what are the WHO criteria for deciding if a district is trachoma endemic, when sub-district surveys are indicated, and what is to be done with impact assessment findings.
3. Ask the participants if any mapping is still required, when it will start, and when it is expected to be completed.
4. Ask the participants if any impact studies have been conducted or when they will start.
5. Ask the participants of the significance of the impact studies (if less than 5% among 1-9 year olds MDA can be stopped; if between 5-9.9% one additional year of MDA followed by impact assessment), F and E activities should continue.
6. The presenter reviews the national A component data, providing opportunity for participants to ask questions, seek clarification or make comments based on their knowledge. The presentation should include information on Zithromax® coverage since programme start up (bar graph may be most useful).
7. The facilitator should be ready to pose questions to the participants. For example, after seeing a bar graph of coverage, a question should be: could someone please interpret this graph?

Day 1 (continued)

Session 7: Review of epidemiology of active trachoma by Region/District and determine the UIG and AIO

Session Summary: This session groups participants by regions or provinces to review the available data for active trachoma, to calculate the UIGs for antibiotic distribution, to set AIOs; to plan when impact surveys will happen and overall to develop a scale-up plan. If not all suspected endemic districts have yet been mapped plans should be made for when this will happen. Much of the information on TF in children may be already available through the Zithromax® application and other sources. If so this session should review and make any adjustments necessary.

Objectives:

1. To review and confirm TF data for endemic districts.
2. To calculate UIGs and AIOs for antibiotic distribution at the district level.
3. To plan for required impact surveys.

Duration: 1 hour

Materials: Laptops and flash drives with Excel sheets

Handouts: Data sheets or memory sticks with data sheets for uploading to group laptops

Training Procedure:

1. If necessary, review with the participants the threshold levels of TF that trigger MDA (> 10% TF among 1-9 year olds) as well as determine whether MDA should be for 3 or 5 years (between 10-29.9% = 3 years MDA; > 30 = 5 years of MDA prior to impact surveys).
2. Review with participants the target groups for MDA: ages as well as form of antibiotics (0-6 months receive tetracycline eye ointment; 6 months to 5 years of age receive Zithromax® pediatric oral suspension; over 5 years of age receive Zithromax® tablets in varying doses according to height).
3. Ask the participants what factor the MOH uses to calculate population growth. This factor will be necessary for setting the AIOs. These calculations may already be incorporated into the data sheet, but the participants should be aware of the process for planning scale up.
4. Divide participants into groups by regions/states/provinces.
5. Ensure that each group has a laptop with the data sheet loaded on it or a paper copy of the data sheet;
6. Ask each group to review the data that is already on the data sheet. It would be helpful to also review WASH data (coverage) in conjunction to TF data in order to reiterate the correlation.
7. Note that if districts are yet to be mapped, then results from the mapping will need to be incorporated when it is available, as the TAP is a living document.

Session 8: Preferred practices for Zithromax® MDA

Session Summary: The ITI supported project to document preferred practices for Zithromax® MDA provides guidance on approaches to improve both the effectiveness and efficiency of MDA. These preferred practices were generated from research in a number of different settings and are relevant to virtually all Zithromax® MDA programmes. Application of the preferred practices is context-specific, however it will be necessary for national programmes to adapt as indicated.

Objectives:

1. To provide participants with a clear understanding of preferred practices for Zithromax® MDA.
2. To help participants understand how these preferred practices can be adapted and adopted to improve both the effectiveness and efficiency of MDA.
3. Preferred practices for Zithromax® management.

Duration: 45 minutes

Materials: Computer and projector for presentation

Handouts: MDA preferred practices manual or print out of the PowerPoint slides (**Annex J**)

Training Procedure:

1. Explain to the participants about the ITI supported preferred practices project, the manual and the reason for its review today.
2. Review each of the key issues highlighted in the preferred practices manual, asking participants questions based upon their understanding of MDA in the country.



Preferred practices for Zithromax® MDA can be adapted to improve efficiency and effectiveness.
Photo: International Trachoma Initiative/
Mark Tuschman

Day 1 (continued)

Session 9: Achieving High Coverage of MDA

Session Summary: A number of issues have been identified that affect high coverage rates with MDA and thus a country's ability to achieve elimination. This session involves group work with each group assigned a particular issue to discuss and make actionable recommendations to increase coverage. The issues include 1) integration of trachoma MDA with other NTDs; 2) the method of distribution and the use of distributors (including social mobilization); 3) Supervision of MDA; 4) Micro-planning and post-MDA reviews (including reporting); 5) Coverage and coverage surveys; and, 6) Costing of MDA. Following the outline of this session are suggested questions for each group. These questions may be tailored to better reflect the national situation. Two hours has been allocated for the group work allowing each group to delve into the details surrounding each issue. The division of groups may be done through self-selection or random allocation or a combination. It is important to have at least one person in each group who can provide leadership and clear guidance to the discussion.

Objectives:

1. To develop action items of how the national program will increase the effectiveness of MDA in order to eliminate blinding trachoma.
2. To develop a framework within which micro-planning can be inserted.

Duration: 2 hours

Materials: Laptop computers or flip chart paper and markers

Handouts: Individual group question

Training Procedure:

1. Explain to the participants that a number of issues have been identified globally as key issues to address to achieve high coverage.
2. Further explain that this session will address these issues within the national context and that the participants will be divided into groups with each group being assigned a particular issue. Present any new formative research or evidence of factors associated with coverage.
3. Present the various issues with the suggested questions (**Annex F**).
4. If the groups have already been established present the groupings; if not divide the groups.
5. Ensure that each group has either a laptop computer or flip chart paper and markers as well as hard copies of the questions.
6. Ensure that each group has a group leader and reporter.
7. Advise the groups that they have 2 hours for discussions and that presentations will be made the following day.
8. The facilitator(s) should circulate among the groups to answer any questions and provide clarification as needed.

Day 2

Session 1: Presentations on Achieving High Coverage

Session Summary: This is a continuation of the group work, looking at issues that need to be addressed to ensure high coverage with drug distribution.

Objective: To present the individual group findings from the previous day and to stimulate discussion for wider input.

Duration: 1 hour

Materials: Laptop and projector

Handouts: None

Training Procedure:

1. Ask each group to present their findings.
2. After each group presentation, open the floor for comments, questions, etc.
3. The facilitator should ensure that someone is noting these contributions from the other groups.

Session 2: Current situation in F & E

Session Summary: This session is designed as a large group discussion to identify the specific F&E activities currently underway in all districts of the country. The F&E worksheet (**Annex G**), which is to be pre-populated before the start of the TAP, still may have some missing information that will need to be compiled during the session. Large scale WASH activities should be considered and the large group discussion is aimed at better understanding current activities in order to determine how best these can be strengthened. The ICTC F&E situation analysis should be distributed to all participants prior to the workshop to inform discussion.

Objectives:

1. To identify organizations active in F&E in all endemic districts.
2. To understand the type of F&E activities currently underway in these settings and how to coordinate these activities for maximum efficacy.
3. To explore ways to embed F&E aspects in existing WASH and community-based health promotion activities.

Duration: 90 minutes

Materials: Laptop and projector

Handouts: None

Training Procedure:

1. A local WASH coordinator presents the findings of the F&E situation analysis and introduces the topic of discussion, showing the Excel sheet.
2. One by one the districts are reviewed and information included. In settings with a large number of districts, this will likely need to be small group work.

Day 2 (continued)

Session 3: Strengths, Weaknesses, Opportunities, Threats (AFE)

Session Summary: This session asks the participants to work in groups and to analyse from the perspective of a SWOT the antibiotic distribution and the F&E implementation in the country. The participants should be divided into 4-6 groups depending on size of the workshop with an even number of groups looking at A and at F&E.

Objectives:

1. To analyse the situation in the country as to implementation of MDA and facial cleanliness and environmental improvement.
2. To provide a basis for developing actions to take advantage of the strengths and opportunities while countering or mitigating the weaknesses and threats.

Duration: 1 hour group work; 30 minutes presentation

Materials: Laptops or flip chart paper and markers

Handouts: Individual group questions

Training Procedure:

1. Divide the participants into 4-6 groups, assigning half the groups A and the other half F&E, making sure that there are people from WASH sector and communication sector in the F&E groups. Depending on the number of WASH participants, it would be good to have some involved in the A group.
2. Ask each group to conduct a SWOT of their respective topic.
3. The facilitator should circulate among the groups to monitor the direction of their work and ensure they will finish within the allocated hour.
4. After an hour, reconvene the participants and ask one of the A groups to present and then continue with the other groups with the same topic.
5. After all the A groups have presented, facilitate a discussion of the various points identifying common themes and differences.
6. Ask the F&E groups to present following the same process as with the A groups. The goal is to consolidate all of the common themes (and differences) to generate specific actions needed.

Session 4: F&E Interventions, Costing, Monitoring, Impact assessments/surveillance surveys and Partnerships

Session Summary: This session looks at several overarching issues that determine successful programs. The participants will again be divided into groups to develop action points.

Objectives:

1. To develop actionable recommendations for ensuring F&E implementation, for ensuring strong supervision, monitoring and reporting; for establishing sound surveillance in post-endemic districts.
2. To develop recommendations and implementation plan for strong and continuous collaboration with the WASH and related (e.g., education, communication) sectors.

Duration: 1 hour for group work; 45 minutes for presentations

Materials: Laptops or flip chart paper and markers

Handouts: Individual group questions; surveillance sheet

Training Procedure:

1. Introduce the session by presenting the different groups and the questions (Annex J) each group will be asked to respond to.
2. Inform the participants that there may be other questions of equal or greater importance within their own national situation and may add or substitute accordingly.
3. Emphasize that the recommendations coming out of their discussions should be action oriented.
4. Divide the participants into groups.
5. Ensure each group has a laptop or flip chart paper and markers.
6. Distribute hard copies of the questions to the appropriate groups.
7. The facilitator should circulate among the groups to monitor the direction of their work answering any questions and providing any needed clarification.
8. After the allotted time, reconvene the participants.
9. Ask each group to present, allowing sufficient time for discussion after each presentation.

Day 3

Session 1: Remaining Issues for Trachoma Control

Session Summary: This session is similar to several of the previous ones in that it identifies issues to be discussed and asks the groups to develop recommendations for the national program to act upon. Though this session suggests some issues, this time could also be used to address any outstanding issues from the work of the past two days. It is recommended that after the fourth day of the workshop, the organizers meet to decide what issues should be discussed. Thus, the questions listed are only examples.

Objective: To develop action points on any remaining issues either as suggested here or others of higher priority to the national program.

Duration: 75 minutes for group work; 45 minutes for presentations

Materials: Laptop computers or flip chart paper and markers

Handouts: Individual group questions

Training Procedure:

1. Introduce the session by presenting the different groups and the questions (Annex J) each group will be asked to respond to.
2. Inform participants that there may be other questions of equal or greater importance within their own national situation and they may add or substitute accordingly.
3. Emphasize that the recommendations coming out of their discussions should be action oriented.
4. Divide the participants into groups.
5. Ensure each group has a laptop or flip chart paper and markers.
6. Distribute hard copies of the questions to the appropriate groups.
7. The facilitator should circulate among the groups to monitor the direction of their work answering any questions and providing any needed clarification.
8. After the allotted time, reconvene the participants.
9. Ask each group to present, allowing sufficient time for discussion after each presentation.

Session 2: Wrap up and Next Steps

Session Summary: This session brings the workshop to a close by summing up the various action points identified during the various group work and ensuing discussions, assigning a point person to ensure they are carried forward, and identifying a time frame by when they should be completed. Prior to this session the majority of the action points should be written up to project to the plenary with the exception of those resulting from the present day's discussions. This could be done on an Excel sheet with columns to list the responsible person and the time frame.

Objective: To develop an overall action plan based on the recommendations made during group work and follow-up discussions.

Duration: 1 hour

Materials: Laptop computer and projector, flip chart paper and markers

Handouts: None

Training Procedure:

1. Project the summary of the action points.

Follow up activities

Following the completion of the trachoma elimination planning workshop, there are a number of tasks to be done. These include:

- Submission of the plan to all participants at the planning meeting so any final input can be obtained prior to completion.
- Merging the trachoma elimination plan with the trichiasis plan (from the first couple of days).
- Convening of a small working group to deal with key nationwide issues such as impact assessments/ surveillance surveys, training, adaption and adoption of preferred practice manuals, etc.



Kissidougou district health personnel and HKI staff in Guinea carefully record the amount of medicine that has been delivered to a storage space in Kissidougou. Photo: International Trachoma Initiative/Joanna Pritchard

Annex A: TT worksheet

Trich										
Trachoma Endemic Region	District			Proportion of the population age 15+ = **%	Remarks					
Region	District	Population	Year of Survey	TT	Backlog	Elimination target (1/1,000 population)	People treated for TT since last survey	UIG	AIO 2015	
	A	0		0.00%	0	0		0		
	B	0		0.00%	0	0		0		
	C	0		0.00%	0	0		0		
	D	0		0.00%	0	0		0		
	E	0		0.00%	0	0		0		
	F	0		0.00%	0	0		0		
Regional total		0			0	0		0		

Trichiasis Prevalence Data

AIO 2016	AIO 2017	AIO 2016	AIO 2017	AIO 2018	AIO 2019	AIO 2020	# Surgeries done			HR- # TT Surgeons
							Baseline year to 2012	2013	2014	
								1000	1500	
										12

You may download an editable Excel version of this form from the ICTC website: www.trachomacoalition.org/TAPplanning

Annex B: Suggested agenda for TT Elimination Planning Workshop

Country XX National Trachoma Elimination Programme Trachoma Action Planning Meeting

Session #	Time	DAY 1 (Trachomatous Trichiasis Planning Meeting)	
	08:30-09:00	Registration	Chair:
	09:00-09:15	Welcome Remarks/Introductions	
1	09:15-09:45	Expectations	
2	09:45-10:05	Setting Workshop Norms	
3	10:05-10:30	Review of SAFE	
4	10:30-10:45	Brief Introduction of the TAP template, Objectives & Process	
	10:45-11:15	Break	
5a	11:15-11:35	WHO guidelines for TT (intervention and elimination)	
5b	11:35-12:10	Evidence-based planning (preferred practices for TT surgical service delivery)	
6	12:10-12:45	National TT Situation: Evidence for Planning	
	12:45-13:45	Lunch break	
7	13:45-14:30	Human resources needed to address the TT surgeries (existing situation in Country X): <ul style="list-style-type: none"> ■ # of TT surgeons trained (where and when) ■ Training approach ■ Current distribution of TT surgeons ■ Current system of supervision of TT surgeons ■ Current productivity of TT surgeons ■ Outreach activities ■ Other relevant information 	
8	14:30-15:15	Group work: Calculating the UIGs and # of surgeries needed to be done (before 2020) for each district	
9	16:00-17:00	Group work: SWOT analysis	
	17:00-17:15	Break	All
	17:15-18:00	Report back, wrap up of Day 1, & day 2 objectives	

Session #	Time	DAY 2 (Trachomatous Trichiasis Planning Meeting)	
			Chair:
1	09:00-09:30	Recap of UIG and AIO (from previous day) and brief review of activities needed to reach the UIGs (set the stage for group work)	
2	09:30-10:45	Moving TT Elimination Forward - Group work (5 groups): 1. Training & certification (changes to the training programmes) 2. Supervision & monitoring outcomes (changes to the supervision programmes) 3. Maximizing productivity (outreach and static services, TT surgical sets per surgeon, social mobilization) 4. National coordination, partner support & prioritization (reporting, national procurement, advocacy) 5. Costing of TT surgery	
	10:45-11:15	Break	
	11:15-11:30	Continue group work	
	11:30-1300	Present back	
	13:00-14:00	Lunch break	
3	14:00-15:00	Next steps & closing of meeting.	
	15:00-17:00	Side meetings (with writing team and facilitators)	

Annex C: Expected Results of a TAP

A Trachoma Action Plan will accomplish the following:

- Delineate the path to trachoma elimination (by the year 2020 or sooner)
 - Use mapping data to generate annual milestones for implementation
 - Highlight gaps between current service delivery data and annual targets needed to reach elimination
- Develop the messages necessary for advocacy
 - Provide metrics to generate compelling statements regarding needs and benefits
 - Clearly articulate actions and resources needed to reach elimination
- Drive stakeholder alignment
 - Bring together interested parties in a collaborative planning process
 - Guide country leadership in critical evaluation of existing partner support and stakeholder activities

Annex D: Preferred practices for trichiasis

Sample slides

What do we know?

- Surgery **output** is currently significantly below that needed to address the TT backlog by 2020
- Growing realization that surgery **quality and outcomes** are not always as good as needed
- Research carried out in recent years provides evidence for improvements to:
 - Surgical procedure
 - Training and supervision
 - Service delivery


Evidence for action...

1. Surgical Management
2. Surgical Training & Quality
3. Surgical Output & Uptake



Surgical management

- Excellent results have been reported from clinical trials using bilamellar tarsal rotation (BLTR)
- Add special lid clamp/plate to BLTR
- WHO TT surgery manual & training of trainers manual (including Head Start).
- Follow WHO "Final Assessment of Trichiasis Surgeons" guidelines
- Epilation is an option if patient does not accept surgery (need to budget for and provide epilation forceps)



Increasing Output

- "Campaign" / "Outreach" surgical provision often accounts for 65-85% of total TT surgeries performed
- "Static" services alone will not be sufficient
- Training general health workers unlikely to deliver the volume of surgery needed
- In high prevalence areas use "dedicated teams"
- Priority to areas with highest UIG (camp approach)

TT Outreach Manual

You may download an editable PowerPoint presentation from the ICTC website: www.trachomacoalition.org/TAPplanning

Annex E: TT questions for group work

Group 1: Training and Certification

1. What criteria are suggested for trainee selection?
2. What recommendations can you make for improving the current approach to training TT surgeons?
3. What non-surgical skills would your group recommend to include in the curriculum of the training of TT surgeons?
4. Would your group recommend establishing a standardized training approach and if so, what steps would need to be taken for this to happen?
5. What steps are needed to implement a system for the certification of TT surgeons?

Group 2: Supportive Supervision

1. What is supportive supervision (from the context of TT)?
2. What are the supervisors' roles and responsibilities in ensuring good quality surgery and good productivity?
3. Who should be doing the supportive supervision of the TT surgeons and how should supervision be organized? (e.g., visits, phone calls, follow up)
4. To whom is the supervisor accountable (both up and down)?
5. Given the current supervision of TT surgeons in country, what changes to supervision are needed to improve quality of care and productivity?
6. What processes (and tools/checklists) should be adopted to measure outcome and make decisions (e.g., what to do if a TT surgeon has a high rate of poor outcomes)?

Group 3: Productivity and monitoring outcomes

1. What is the recommended number of TT surgeries per surgeon per year and what is the recommended number of TT surgeries per outreach day (assuming one surgeon and 2-4 assistants)?
2. What factors are important for maximizing productivity (what evidence do you have to support your decisions on factors)?
3. What is the role of outreach to improving productivity and increasing access? (Use evidence from outreach in the country)
4. Can dedicated TT surgical teams be used to increase productivity? If yes, how can these be constituted? Ideally, who should make up a TT surgical team?
5. What is the minimum # of TT surgical sets per surgeon?
6. What steps need to be taken to improve the quality of TT surgery (reduce surgical failure)?

Group 4: Coordination & Reporting

1. What are your recommendations to enhance coordination at the national, regional, and district levels and among partner organizations in regards to reporting, procurement and advocacy?
2. How would you prioritize districts for implementation?
3. For those districts with a low prevalence of TT and able to meet their UIGs within the next several years, what are your recommendations for managing the remaining cases and incident cases?
4. What do you recommend in terms of reporting (what indicators: e.g., people receiving surgery against targets, productivity of TT surgeons, productivity of outreach, # of good outcomes at follow up?)
5. What does your group recommend in terms of efficient and effective procurement (and dissemination) of instruments and consumables?

Group 5: Mobilization

1. What is the current role of the general health worker / community worker in identifying TT patients and how could this be improved?
2. What are some of the recommended approaches to mobilizing cases (and family members) for surgery (what evidence do you have that shows these approaches work)?
3. Since about two out of every three TT cases are women, what mobilization approaches are necessary to reach women?
4. What should the trachoma programme do to manage other causes of vision loss (e.g., cataract)?

Group 6: Costing of surgery

Using the costing sheet provided, identify the costs for the following aspects of a surgical program:

1. Cost of training TT surgeons
2. Cost of instruments (TT kits, autoclaves, loupes, etc.)
3. Cost of consumables (sutures, gloves, gauze, etc.)
4. Cost of conducting outreach campaign
5. Cost of supervision
6. Cost of patient follow-up
7. Cost of patient mobilization



These children in rural Uganda received donated Zithromax® during MDA at their school. Photo: Pfizer

Annex F: TF & MDA Worksheet

Trachoma prevalence and MDA data by district														
Region	District	Population (year)	Population Growth	Year of Most Recent Survey/IA	TF %	Past MDA	ongoing or planned MDA	Past distribution	Projected					
						Impact Assessment	Surveillance survey	2014	2015	2016	2017	2018	2019	2020
						Current Zithromax distribution Y/N	3 Years or 5 Years							
		0	0.0	0	0.00									
		0	0.0	0	0.00									
		0	0.0	0	0.00									
		0	0.0	0	0.00									
		0	0.0	0	0.00									
		0	0.0	0	0.00									
		0	0.0	0	0.00									
		0	0.0	0	0.00									
		0	0.0	0	0.00									
		0	0.0	0	0.00									

You may download an editable Excel version of this form from the ICTC website: www.trachomacoalition.org/TAPplanning

Annex H: Suggested agenda for Active Trachoma Elimination Planning Workshop

Country XX National Trachoma Elimination Programme Trachoma Action Planning Meeting

Session #	Time	DAY 1 (A,F,E Planning)	
	08:30-09:00	Registration	
	09:00-09:15	Welcome Remarks/Introductions	Chair:
1	09:15-09:45	Expectations	
2	09:45-10:05	Setting Workshop Norms	
3	10:05-10:30	Review of SAFE	
4	10:30-10:45	Brief Introduction of the TAP Template, Objectives and Process (and criteria for intervention/stopping intervention)	
	10:45-11:15	Break	
5	11:15-11:30	Review of the TT plan (work from Mon/Tue)	
6	11:30-12:00	TF prevalence in the districts, current MDA, including coverage	
7	12:00-12:45	Group work (by district): Review of data on TF, calculation of UIGs, scale up plan, surveillance)	
	12:45-13:45	Lunch break	
	13:45-14:00	Present back	
8	14:00-14:45	Achieving elimination of active trachoma: preferred practices for MDA	
9	14:45-16:00	Achieving high coverage of MDA: group work	
	16:00-16:30	Break	All
10	16:30-17:15	Group work continued	

Session #	Time	DAY 2 (A, F, E Planning)	
			Chair:
	09:00-09:15	Day Three review / discussion of day four objectives	
1	09:15-10:15	Present back (previous day work on MDA)	
2	10:15-11:45	Situation of national F&E efforts (Large group or small group, depending on number of districts)	
	11:45-12:00	Tea break	
3	12:00 -13:00	SWOT (3 groups for A, 3 groups for FE)	
	13:00- 13:30	Presentation of findings from SWOT	
	13:30-14:30	Lunch break	
4	14:30-15:30	Group work on F&E, costing, monitoring, and impact assessments/surveillance surveys	
	15:30-16:00	Break	
	16:00-16:45	Present back	


Session #	Time	DAY 3 (A, F, E Planning)	
1	08:30-09:45	Review of broad based issues for trachoma control (introduce group work)	
	09:45-10:30	Present back	
	10:30-11:00	Tea break	
2	11:00-12:00	Next steps, review of communiqué, closing of meeting	
	12:00	Closing	

Annex I: Preferred practices for MDA

Sample slides

The approach...


- Issues/challenges
 - Practices from the field that address the issues
- Identify supplementary material
 - Avoid duplication
- Preferred practices NOT "written in stone"
 - As programmes mature, situations change
 - As experience grows, new ideas emerge
 - As technology changes, new approaches are possible



Section 1: National coordination

Preferred practices:

1. Invest resources in national coordination
2. Have a strong National Trachoma Task Force (includes partners)
3. Base budget on practical national & country plans
4. Strong coordination between NTD and eye care



Section 3: Micro-planning

Preferred practices


- Micro-planning for efficiency and effectiveness
- Micro-planning done annually
- Use standardized tools
- Engage stakeholders in micro-planning
- Make micro-planning transparent
- Link micro-planning to accountability



Section 6: Intervention

Preferred practices:

1. Planning for distribution system evidence based (central site distribution vs. house to house distribution)
2. Selection of distributors an important part of community engagement
3. Community mobilization requires community engagement as early as possible



You may download an editable PowerPoint presentation from the ICTC website: www.trachomacoalition.org/TAPplanning

Annex J: Antibiotic questions for group work

Note: Some of these topics are context-specific. For example, where Zithromax[®] MDA is not to be coordinated with distribution of drugs for other Preventive Chemotherapy and Transmission Control (PCT) NTDs, then the topic on integration will likely not be relevant. In settings that have had Zithromax[®] MDA for a number of years, the questions related to distribution type and distributors and the questions related to cost may not be relevant. If however, the country has low coverage, it may be appropriate to consider other approaches to distribution.

Group 1: Zithromax[®] MDA coordinated with other PCT NTDs

1. How does the distribution of Zithromax[®], coordinated with other PCT NTDs impact coverage of Zithromax[®] MDA? Please consider both positive and negative impacts.
2. How can any negative impact be mitigated?
3. Where are the most appropriate points of coordination? (e.g., training, supervision, reporting, others) and what steps are needed to maximize coordination without reducing coverage?
4. Where is coordination less appropriate and what activities are needed to ensure that gaps do not emerge?

Group 2: Distribution type & distributors

1. What are the most appropriate approaches to distribution to achieve high coverage (e.g., house to house, central site, other, combined)?
2. Who are the most appropriate distributors (and why them)? What are the implications for using this group/cadre? (e.g., training, supervision, cost)
3. Who should make up a distribution team?
4. What strategies are needed to improve the distribution model and improve the skills of distributors?
5. What is the recommended number of population per distributor?
6. What are the key components of mobilization?

Group 3: Supervision

1. What is supportive supervision (from the context of Zithromax[®] MDA)?
2. What are the supervisors' roles and responsibilities in ensuring that high coverage is achieved?
3. Who should be doing the supportive supervision of MDA in the field and how should supervision be organized? (e.g., visits, phone calls)
4. Who is the supervisor accountable to (both up and down)?
5. Given the current supervision of Zithromax[®] MDA in country, what changes to supervision are needed to improve MDA coverage?

Group 4: Micro-planning at the district level

1. In most settings, high quality micro-planning has been cited as critical to program success. In your context, what does quality micro-planning mean? What are your recommendations for strengthening micro-planning?
2. Who are the critical partners or stakeholders that should be involved in micro-planning? Also, what is the role of the central government in micro-planning?
3. What information from the previous year's Zithromax[®] should be used for micro-planning? What other information would be useful to make micro-planning both effective and efficient?

Group 5: Coverage

1. What steps can be undertaken during MDA to assess coverage and take immediate remedial action (mop up)?
2. Currently what are the likely reasons for poor coverage and what steps are needed to improve coverage?
3. Within a district what is recommended to deal with pockets of low coverage?
4. Within a district what is recommended to deal with overall low coverage?
5. Coverage surveys (usually done 3-6 weeks after MDA) often have different findings from field (administrative) coverage; what situations might be appropriate for doing a coverage survey?

Group 6: Costing of MDA

Using the costing sheet, estimate the costs for the following components of an MDA:

1. Training of different cadres (who needs to be trained?)
2. Supplies (dose poles, registries, Information, Education, and Communication materials, etc.)
3. Transport of supplies and drugs to Community Drug Distributors
4. Community mobilization (including radio, etc.)
5. Supervision
6. Distributors (per diems, transport, “motivations”)
7. Reporting from community to district level
8. Management of common side-effects (e.g., paracetamol)



People gathered at the North Shoa Zonal Hospital in Debre Berhan for a trichiasis surgical campaign. Photo: Fortunate Shija

Annex K: F&E and Coordination questions for group work

Note: Some coordination and monitoring issues are context specific and some issues outlined in the questions may need to be revised accordingly. In both F&E behaviour change discussions, the information gathered through the F&E situational analysis on knowledge, practices and behaviours should be taken as the starting point as it will inform the messaging developed.

Group 1: Facial Cleanliness

1. What are the existing opportunities in the districts to promote facial cleanliness (who is doing what, where, and how can existing programmes be strengthened)?
2. What are the cultural beliefs around face washing within your target communities? Who generally maintains a clean face within the community and are there any positive or negative associations with this behavior?
3. How do you propose that we assess progress in facial cleanliness? What indicators could be used and how could information be collected on them? Which of these indicators could be based on attitudes, self-efficacy, community efficacy, and/or the belief that proper face washing practices would have an impact on trachoma reduction?
4. What is the role of the various levels (district, regional, national) and other departments of the government system (not just health) and partners to ensure face washing activities are being implemented?
5. What is the communication plan regarding facial cleanliness? How will community mobilization be undertaken?
6. If water availability is a key barrier to face washing, what creative strategies exist as an alternative?

Group 2: Environmental Improvement

1. What are the existing opportunities in the districts to promote environmental improvement (who is doing what, where, and how can existing programmes be strengthened)?
2. What are the cultural beliefs around environmental improvement within your target communities? Who generally maintains a clean household environment within the community and are there any positive or negative associations with this behavior?
3. How do you propose that we assess progress in environmental improvement? What indicators could be used and how could information be collected on them? Which of these indicators could be based on attitudes, self-efficacy, community efficacy, and/or the belief that proper environmental improvement practices would have an impact on trachoma reduction?
4. What is the role of the various levels (district, regional, national) and other departments of the government system (not just health) and partners to ensure environmental improvement activities are being implemented?
5. What is the communication plan regarding environmental improvement? How will community mobilization be undertaken?

Group 3: Monitoring and Reporting

1. What are the existing reporting mechanisms for F&E and what can be done to improve these reporting mechanisms for trachoma planning?
2. Develop a diagram that illustrates the flow of reporting (for each aspect of SAFE) starting at the community level to the national level and back down. If in a setting where Zithromax® MDA is coordinated with other NTD PCTs, recommend how this could be improved.
3. Make recommendations for the reporting roles of all supervisors at each point on the diagram.
4. What are the gaps in the existing reporting and monitoring guidelines for severe adverse events (SAEs: defined as resulting in death, hospitalization, disability)? What is needed to improve the guidelines?

Group 4: Coordination/partnership between eye care & NTD

1. At the district level what activities are needed to ensure good coordination between eye care & NTD to achieve implementation of the full SAFE strategy?
2. What concrete reporting would be expected to see that this is happening?
3. What would trigger action (and by whom)?
4. What obstacles are foreseen to coordination and partnership and what needs to be done to mitigate these obstacles?

Group 5: TAP as “living document”

1. What are the steps proposed for annually updating the TAP with additional trachoma mapping data?
2. Provide concrete recommendations on how the TAP should be used to monitor progress, identify gaps, update progress to elimination, etc.



Trichiasis case finders in Ethiopia practice using torches as they examine the eyes of villagers for signs of trichiasis. Photo: Esmael Habtamu

Annex L: Remaining questions

At the end of day two of the AFE planning session, the facilitators should decide what are the key issues remaining to be addressed. The list below is only given as an example of issues that have arisen in the past.

Group 1: Revitalizing the National Trachoma Task Force (re-draft the NTTF if needed)

1. What are the recommended roles and responsibilities of the NTTF?
2. Who are the proposed members of the NTTF?
3. What are the roles and responsibilities of an NTTF steering committee?
4. How will the NTTF interact with regional and state level personnel?
5. What is the recommended relationship between the NTTF and NTD?

Group 2: Inter-sectoral collaboration

1. What needs to be done to operationalize inter-sectoral collaboration at the national, regional and district levels?
2. What are the recommended steps to inter-sectoral collaboration?
3. What are the possible obstacles to inter-sectoral collaboration?
4. How can the obstacles be overcome?

Group 3: Alignment with NTD Master Plan

1. What are the next steps to align the TAP with the NTD Master Plan?
2. What might be recommended to other NTDs to improve coordination with trachoma?
3. How could the trachoma “community” help strengthen other NTD programmes?

Group 4: Advocacy/sensitization

1. What national, state, and district advocacy activities would assist with implementation of the TAP and elimination of blinding trachoma?
2. Outline a proposed national advocacy plan. Define the next steps.

Group 5: Operational research questions

1. What operational research would help guide the national plan in achieving the elimination goals?

Group 6: Capacity Building

1. Please define the critical areas for capacity building at the national, state, LGA, community levels to ensure achieving GET2020 goals.
2. Please define what needs to happen to put into place capacity building for the trachoma elimination program.

Group 7: National level coordination issues

1. What aspects of the TAP are best managed centrally versus managed at the district level? For example, should surveillance be designed nationally with training of district staff done centrally? Should impact assessments all be done by one organization to improve standardization?

Annex M: F&E Situation Analysis

Protocol and Methods for Trachoma Situational Analysis (F&E module)

Overview: The face washing and environmental improvement situational analysis is composed of several information gathering activities ranging from collation of quantitative data to conducting qualitative interviews with key stakeholders that influence face washing and environmental improvement. The collective information for this activity will be used to further guide F and E programming and activities within the context of the national Trachoma prevention SAFE strategy. This is meant to be a first step to developing a joint program approach to address F&E in your country, and will need to be followed by district focused analyses to understand the partners, resources, and existing WASH, trachoma and F&E activities taking place at district and sub-district levels before developing a detailed implementation plan that involves all key stakeholders.

How F & E is defined in this situational analysis. It is well recognized that investment in sustainable water and sanitation infrastructure is critical to overall development. Tapping into local knowledge from the government and understanding community needs and preferences are also important sources for determining the most suitable type of WASH interventions (both 'hardware' and 'software' within each targeted region for each area. In the context of available funding for Trachoma specific interventions, F & E activities are defined as a set of targeted interventions primarily focused on behavioural change and the promotion of healthy behaviours and practices around personal hygiene with emphasis on facial cleanliness and, environmental cleanliness and sanitation for the elimination of blinding Trachoma. This can be achieved through various mechanisms and interventions including:

- Developing social norms on cleanliness and hygiene practices / habits driven by community dialogue.
- Capacity building and infrastructure development* around water and sanitation (ie: construction, use, sustainability, and management)
- Development of tailored hygiene programs that serve to integrate and/or coordinate with existing NTD, Trachoma and other relevant health or WASH programs.

** In principle, funding will be reserved for Social and Behaviour Change Communication (SBCC) activities unless specific interventions require minor hardware investments.*

What components are included in the F & E situational analysis? The national level assessment will explore the contribution of the national health policies, water and sanitation policies, and any other relevant health management systems or health services that create an enabling environment both at the national and district operational levels to effectively implement hygiene and sanitation interventions.

Objectives:

- To review the national health goals, policies, strategies and plans.
- To assess the strengths and weaknesses of the institutional support systems.
- To assess the health service design and implementation strategies at the national and district level.
- To assess the flow of information and materials to and from the national and district levels.

Overall Topics to Include in Situational Analysis Checklist

- I. Demographic, Climate, and Disease Information
- II. Trachoma and WASH Policy and Coordination Information
- III. Behavior Change Communication Tools for Trachoma and WASH
- IV. Advocacy
- V. Media channels

International Coalition for Trachoma Control (ICTC)

VISION:
Global Elimination of blinding Trachoma by 2020.

MISSION:
To act as a catalyst for the implementation of the SAFE strategy in support of endemic countries' trachoma control programs.

ICTC has a highly committed and professional multi-stakeholder membership, including Non-Governmental Development Organizations, donors, private sector organizations and research/academic institutions that demonstrate a commitment to GET 2020 and the WHO-endorsed SAFE strategy.

ICTC members at time of publication:



ICTC observers at time of publication:



ICTC International Coalition for Trachoma Control

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