Vision & Development
Ophthalmology in Development Cooperation

Trachoma and Human Resources Development
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ARTICLES

Dr. Amir B Kello
Trachoma and the SAFE Strategy .................. 4

Esmael Habtamu
Human resources for delivering TT surgery ........ 6

Dr. Teshome Gebre
Human resources for trachoma MDA .............. 8

PRACTICE

Adugna Amin
Implementation of the F&E component
in Tigray, Ethiopia .............................. 10

Dr. Amanuel Kidane & Getachew Aberra
Implementation of TT surgery in Tigray, Ethiopia . 12

Solomon Gadissa
Implementation of MDA in Oromia, Ethiopia .... 14

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Trachoma has caused 1.9 million people to become blind or visually impaired and puts hundreds of millions of the poorest of the poor at risk of infection and losing their sight forever. It is endemic in 42 countries in Africa, the Middle East, Central and South America, Asia and Australia. Although significant progress has been made in the fight against trachoma over the last two decades, it still remains the major cause of infectious blindness worldwide. Trachoma is preventable and could be controlled by implementing the WHO-recommended SAFE strategy (see page 4).

Trachomatous trichiasis (TT) is the late, painful complication of trachoma, leading to irreversible blindness. Addressing this late complication needs trained eye health personnel who are unfortunately not within reach for those in dire need of treatment. To end the suffering, it is crucial to train cadres that could provide high quality surgery for patients with TT (see page 6).

Mass drug distribution clears the infectious load of the bacterium responsible for trachoma – Chlamydia trachomatis. Tens of thousands of community health workers and volunteers, who deliver the Pfizer-donated Zithromax® and tetracycline eye ointment to the affected communities also need to be trained (see page 8).

Ethiopia is the country with the highest burden of disease for trachoma in the world. Light for the World supports the implementation of the SAFE strategy in the Tigray Region and mass drug administration (MDA) in parts of the Oromia region (page 10).

Together with local and international partners, Light for the World is contributing towards the elimination of blinding trachoma in endemic countries by the year 2020. Thank you for your continuing support to achieve better eye health and leaving no one behind in the poorest regions of our world.

Dr. Amir Bedri Kello,
Director Eye Health/NTDs

We thank our partners!
Trachoma is the leading cause of infectious blindness in the world. Trachoma affects mainly the poorest of the poor living in remote villages in endemic countries of Africa, the Middle East, Central and South America, Asia and Australia.

In order to eliminate trachoma as a public health problem, it is essential to know its distribution and prevalence around the world. This is what was achieved with the Global Trachoma Mapping Project (GTMP), which represents the largest infectious disease mapping project in public health history. GTMP used modern smartphone technology to map trachoma, one of the oldest eye diseases known to mankind. It was launched in December 2012 and completed in January 2016; data from 2.6 million people in 29 countries using Android smartphones was collected and transmitted. On average, one person was examined every 40 seconds during the three-year project.

Trachoma is endemic in 42 countries with nearly 182 million people living at risk of getting infected. An estimated 1.9 million people are already blind or moderately to severely visually impaired due to trachoma. There are 3.2 million trachomatous trichiasis cases that could result in visual impairment and blindness if left untreated. Africa represents the most affected continent with roughly 170 million people at risk, which represents 93% of the world’s population at risk of trachoma infection. Africa also carries 72% of global trichiasis cases.

Trachoma is responsible for 1.4% of global blindness and an estimated annual productivity loss of up to US$8 billion.

Trachoma is caused by a bacterium Chlamydia trachomatis, which is transmitted through contact with contaminated hands, fomites and bedding as well as eye-seeking flies that come into contact with eye and nasal discharges from infected persons. Environmental risk factors that favour the transmission of the disease include poor hygiene, overcrowded households, shortage of water and inadequate latrine and sanitation facilities.

Pre-school age children represent the major source for Chlamydia trachomatis and repeated infections with the bacterium in early childhood results in chronic kerato-conjunctivitis that leads to scarification of the upper tarsal conjunctiva. This scarification leads to entropion/trichiasis and eyelashes turning inwards and scratching the cornea with every blinking of the eyes resulting in severe pain and irreversible blindness.

Trachoma is mainly the disease of children and women. Children are mainly affected by the active disease and late complications are usually seen in adults. However, in hyper-endemic communities for trachoma, late complications can even arise in children and young adults. Due to their close contact with children, women are up to four times more affected with late complications of trachoma resulting in visual impairment and blindness than men.

It is easy to understand how debilitating trachomatous trichiasis could be when one considers the fact that on average a person blinks about 19,000 times per day in the waking hours with each blink resulting in the scratching of the sensitive cornea by the in-turned lashes causing severe pain. Trachoma causes misery not only for affected individuals but also for their families. When parents become blind due to trachoma, children are usually taken out of school.
to look after them depriving them of their chance for education and a better life, perpetuating the cycle of poverty.

Trachoma can be eliminated as a public health problem by implementation of the WHO recommended strategy known as the SAFE strategy that was adopted in 1993. SAFE is an acronym that stands for Surgery to treat trachomatous trichiasis, the late complication of the disease, Antibiotics to clear infection through mass drug administration, Facial cleanliness and Environmental improvement to prevent the disease from recurring.

In 1996, WHO launched the WHO Alliance for the Global Elimination of Trachoma by 2020 (GET2020). The Alliance for GET2020 is a partnership which supports implementation of the SAFE strategy by Member States, and the strengthening of national capacity through epidemiological surveys, monitoring, surveillance, project evaluation, and resource mobilisation.

The elimination of trachoma as a public health problem is defined as: (i) a prevalence of trachomatous trichiasis “unknown to the health system” of < 0.2% in adults aged ≥ 15 years (approximately 1 case per 1000 total population); and (ii) a prevalence of trachomatous inflammation-follicular in children aged 1—9 years of < 5%, in each formerly endemic district.1

So far, seven countries have reported having achieved the target of elimination of trachoma as a public health problem (Cambodia, China, The Gambia, Ghana, Iran, Laos and Myanmar), while three countries (Oman, Mexico and Morocco) are already validated by the WHO for having achieved the elimination target.5

Women after surgery in Quiha, Tigray. Women are up to 4× more affected by TT than men.

REFERENCES


4. The Global Trachoma Mapping Project (GTMP) [Available at: https://www.sightsavers.org/gtmp/ accessed on 28 May, 2017]


In most trachoma endemic countries, there are not enough ophthalmologists to treat people with TT. Therefore, in many programmes there has been a task shift, with trichiasis surgery being performed by non-physician cadres such as ophthalmic nurses and other mid-level health workers including nurses and health officers. These are sometimes referred to as TT surgeons or Integrated Eye Care Workers (IECWs), who have received a four-weeks focused training on trichiasis surgery. However, this has many challenges including identifying appropriate trainees and providing high quality surgical training, locating and equipping them in relatively remote rural areas and providing sustained support and supervision.

Selecting the right personnel for training has been a major challenge for trachoma control programmes. It is recommended that programmes should ensure that individuals selected for IECWs training should have both the aptitude for surgery and the interest to serve in relatively remote rural health facilities. However, It is not uncommon to see IECWs selected for training regardless of their aptitude and interest. Training of IECWs must follow the WHO Trichiasis Surgery for Trachoma Manual. Training programmes need to be led by an ophthalmologist experienced and standardised in trichiasis surgery who has expertise in surgical training. The WHO recommends training uses a mannequin known as HEAD START (Human Eyelid Analogue Device for Surgical Training And skills Reinforcement in Trachoma). This provides trainees with the opportunity to learn and practice all the major steps of the trichiasis surgical procedure prior to operating on patients. At the end of the training each surgeon must pass the WHO certification process before being allowed to practice. Following certification, the IECWs return to their respective health facilities where they are expected to perform TT surgery amongst other duties. Results from a clinical trial and subsequent programmatic experience suggest that IECWs can perform TT surgery to a similar standard to ophthalmologists. As a result, thousands of IECWs have been trained and deployed in trachoma endemic countries during the last 10 years.

In some programmes, it has been difficult to maintain services because individuals who have been trained in TT surgery leave the programme, move to other positions or get promoted, and are therefore no longer available to provide a service. A study showed that, among IECWS trained in a programme, 59% were no longer in a position to perform TT surgery. Programmes should think carefully on how to retain their trichiasis surgeons at least for few years based on their local context and should create a favourable and encouraging employment environment and devise a method of continuously supporting and motivating IECWs after they have been deployed.

Despite the unprecedented effort to clear the huge TT backlog and deployment of several IECWs, productivity is less than anticipated in some programmes. A couple of studies conducted in Ethiopia and Tanzania showed that the average productivity of IECWs was 41 and 22 cases per year respectively. This is very low compared to the huge backlog of unoperated TT in such trachoma endemic countries. IECWs often have many other competing activities.
responsibilities and would, therefore, not be made available by their respective health centres to deal with TT surgery alone. Training community members to identify, counsel and refer TT cases for surgery shares the burden of IECWs and improves their productivity. 

Continued supportive supervision is crucial both for improving output and outcome of trichiasis surgery. However, unfortunately surgical programmes often tend to overlook its importance. Lack of supportive supervision has been cited among the major reasons for poor surgical productivity. Among “supervisors” interviewed in a study, about half never met with their surgeons to discuss trichiasis surgery. On the other hand, even if conducted, the quality of supportive supervision may be an issue in most trachoma control programmes. Supervisors themselves need standardised training on supportive supervision processes and skills and so they are capable of transferring skills and providing comprehensive support in all aspects of TT surgery including programme management and providing hands-on training to ensure high-quality sustainable surgical services.

Supply chain managers or coordinators are an integral part of the TT surgery service delivering team. Buying surgical consumables and materials is not sufficient to effectively run a surgical programme. However, it requires regular logistical planning, supply chain management and material audit at all levels. Surgical kit availability means that the IECWs have the necessary surgical material with them at the health facility at all times so that they can provide the surgical service anytime patients present. One study found a significant association between performing more surgery and reported good availability of surgical consumables.

Overall, TT surgery can successfully be performed by non-physician cadres. However, developing human resources for TT surgery comes with considerable challenges that would require sustained attention and effort, and would need a team comprised of IECWs, community based case identifiers, technical supervisors, and coordinators.

REFERENCES

The trachoma mass drug administration (MDA) approach was modelled on the guiding principles and attributes of its forerunner, the community directed treatment with ivermectin (CDTI). The CDTI was adopted as the principal strategy for the control of onchocerciasis by the Joint Action Forum (JAF), the governing body of the African Programme for Onchocerciasis Control (APOC) in 1997 (Amazigo et al 2012). CDTI, also known as community-directed intervention (CDI), is a bottom-up approach to public healthcare delivery that empowers communities to take care of their own health. Worldwide, onchocerciasis is a very important infectious cause of blindness, being second only to trachoma in number of persons affected (Boatin & Amazigo, 2016).

CDTI was a result of multi-country operational research conducted in 1995 under the auspices of WHO/TDR. The search for a more sustainable and cost-effective strategy that can address the challenges of access and coverage in Sub-Saharan Africa, where health systems lack human resources and structures, was concluded with the establishment of the CDTI strategy (WHO/TDR 2008, 2010). CDTI is based on the principle of community participation. The key element of CDTI is that the villagers who live in meso- or hyper-endemic communities decide themselves on who should become community-directed drug distributors (CDDs) and plan the period, dates, locations and modes of village-level distribution (WHO, 1998). Prior to this, there was a slightly different approach called community-based ivermectin treatment (CBIT), which was primarily led and governed by the healthcare
delivery system. The CDTI however outsmarted CBIT due to its special features like sustainability, community ownership and empowerment and cost-savings to the health system (Amazigo et al, 1998).

Again, building on the experiences of the Onchocerciasis Control Programmes in Sub-Saharan Africa, the height-based treatment schedule was adopted for trachoma MDA with azithromycin. Earlier experience in trachoma control activities in South Africa and Tanzania have used community volunteers to distribute antibiotics successfully. Better performance (i.e. good coverage) was seen when direct incentives (cash or in-kind compensation) were not given. Volunteer distributors seemed to be motivated by political goodwill, personal satisfaction and altruistic fulfilment. The WHO set a target coverage of 80% for azithromycin distribution (Taylor 2008).

The trachoma MDA is one of the four complementary components of the SAFE strategy. The implementation unit for trachoma MDA is the district (or its equivalent depending upon the administrative structure of each endemic country). At district level, training of trainers (TOT) is conducted for health workers that are drawn from frontline health facilities (usually health centres and health clinics or stations). The trained health workers, who eventually assume the role of MDA supervisors, will in turn return to their respective health facilities or sub-distRICTS (as the case maybe) and recruit and train community health workers and volunteers. Depending upon the endemicity of trachoma in the country under consideration, this exercise could be massive (involving several hundreds of district health workers and tens of thousands of community health workers and volunteers as in the case of countries like Ethiopia) or modest (involving a limited number of district health workers and a couple of hundred community health workers and volunteers as in the case of small endemic countries like Fiji, Kiribati or Vanuatu).

To date, the largest trachoma MDA was held in Amhara National Regional State (ANRS), north western Ethiopia. In this integrated malaria and trachoma campaign that was conducted in November 2010, a total of about 10 million people were targeted in 76 districts and 1,687 sub-districts (communities) while a total of 13,675 community volunteers, 4,559 health extension workers and 1,233 district supervisors were deployed for a week-long campaign which culminated in treating 9.41 million people (94%) with Pfizer-donated Zithromax® and tetracycline eye ointment (only for pregnant women and infants <6 months). During this integrated campaign, a total of 89,579 febrile cases were screened with rapid diagnostic test (RDT) and treated with anti-malaria drugs concurrently. This way the trachoma MDA served as a platform to screen and treat malaria cases in each village and individual households during the peak malaria transmission season. All the community health workers and volunteers were given adequate training and guidance on how to screen and manage acute malaria cases during the MDA campaign. This was a win-win situation both for the malaria and trachoma programmes in Ethiopia. Most importantly, it should be noted that it is the power of partnerships which involved a host of credible stakeholders, including the Federal Ministry of Health, the Amhara Regional State government, the Lions Clubs International, Pfizer Inc., The Carter Center and the International Trachoma Initiative, that helped achieve such an outstanding result. Effective communication and powerful health education, meticulous planning and efficient resource allocation are essential for the successful organisation and management of trachoma MDAs.

The distribution of Human Resources for Health (HRH) is meagre in most rural areas of Africa where trachoma is endemic. It is therefore incumbent upon all trachoma programmes to effectively mobilise community health workers and volunteers if elimination of blindness from trachoma is to be achieved as planned. Trachoma MDA should be viewed as an integral part of the treatment of other neglected tropical diseases (NTD) and also as part of the general eye health programmes. The programme managers in these settings have shared responsibilities. MDAs and community health workers are the gateways for Universal Health Coverage (UHC) that provide stepping stones to realising the noble theme of the Sustainable Development Goal (SDG), where “no one should be left behind”.

REFERENCES

Implementation of the F&E Component

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Trachoma is a disease of poverty and highly prevalent where environmental sanitation and hygiene is an issue. According to the Global Trachoma Mapping Project (GTMP) survey which was conducted in 2013, Ethiopia is one of the most severely affected countries with an estimated population of 72 million people living in rural trachoma endemic areas.
The GTMP which was conducted in Tigray, one of the regional states in the northern part of Ethiopia, has also demonstrated that over 4.4 million people live in proven trachoma endemic areas of rural Tigray. The prevalence of active trachoma in children aged 1–9 years ranged from 15.7 % to 40 % in the region.

After the completion of the GTMP, Light for the World began supporting the regional trachoma elimination programme in 2014 using the SAFE strategy that is endorsed by the World Health Organization (WHO). So far, all trachoma endemic districts of the region are covered by the surgery and antibiotics (S & A) components of the SAFE strategy through partnerships with DFID/SSI and also USAID/HKI/RTI. However, the facial cleanliness and environmental improvement (F & E) components of the SAFE strategy remain challenging.

Light for the World has supported the Tigray Regional Health Bureau (TRHB) to implement a three-year F & E pilot project with funding from the Austrian Development Agency (ADA) in five hyper-endemic districts of the Southern Zone of Tigray. This project supported the construction of 44 water schemes, which benefited 11,050 rural communities; in addition, Light for the World has also supported the establishment of a water management committee at each water scheme and provided training on the proper management of water facilities for 382 water committee members.

Because of the importance of building the capacity of service providers if the trachoma elimination goal is to be achieved, 235 health extension workers (HEWs), who are already intervening at grass roots level and are thus really close to all the rural households, have been given basic training on trachoma and the SAFE strategy; this will enable them to support the community to achieve a positive behavioural change in hygiene and sanitation practices.

In Tigray, every rural woman is a member of the Health Development Armies (HDAs) through what is known as one-to-five networking. HDAs have their own women development army leaders who are supervised by the HEWs. Hence, these networks were used as the main platform to cascade the training to the HDAs.

Over the last three years, 35 health extension supervisors from different health facilities, 10 health experts from district health offices and 660 community leaders who are both respected and have the potential to influence the community have been trained on community level trachoma interventions to achieve the elimination target.

To supplement the community based facial cleanliness and environmental improvement interventions, Light for the World has also supported the transmission of frequent trachoma prevention messages through the local radio stations that can potentially reach the entire five million population of the Tigray region.

Different awareness raising materials such as posters, teaching guides or booklets, and brochures were also printed and distributed to improve the knowledge of the targeted community about trachoma. With these interventions targeted at trachoma endemic communities, it is estimated that more than 725,839 peoples have benefited from the project.

In addition to intervening at community level, Light for the World strongly believes that schools are the ideal places to address children and the communities in general as the students are members of the community and have the ability to influence their parents regarding hygiene and sanitation. So far, the project has supported the strengthening of school-based interventions through school WASH clubs, Parent Teacher Associations (PTAs) and also school teachers’ training.

Accordingly, 85 school WASH coordinators, school principals, PTA leaders, school supervisors and health extension supervisors were trained on trachoma-WASH integration. The training was cascaded to the students through one-to-five student networks by their respective homeroom teachers. With the school based interventions, around 15,525 students are believed to have benefited from the project.

As trachoma prevention is closely linked to increased access to water and sanitation, it is essential to ensure the active engagement of other sectors including water, education, finance and economic development agencies to make sure that they take the trachoma burden of the districts into consideration during the planning and implementation of relevant programmes. So far, 130 sector representatives from water, health, education, finance and economic development have been sensitised by participating in different awareness creation, planning and evaluation workshops of the project.

By incorporating the best practices from the ADA supported project, we are currently supporting F & E projects in nine trachoma endemic districts of Central Zone of Tigray. This project has both hardware and software components and ensures full SAFE implementation in Central Zone of Tigray. Additionally, with DFID/SSI, we are also planning to implement full SAFE strategies in nine additional hyper-endemic districts of the region.
Implementation of TT surgery in Tigray, Ethiopia

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Tigray region is one of the 9 administrative regions of Ethiopia with an estimated population of 5 million people. Administratively, the region is divided into 7 zones and 52 districts of which 34 are rural and 18 are urban districts. In the region, there are 4 secondary eye care units and 19 primary eye units providing eye health services.

With funding from SightSavers, Light for the World coordinated the Global Trachoma Mapping project (GTMP) in Tigray region that was carried out from January – March 2013. All 34 rural districts were mapped for trachoma. The mapping result indicated that the prevalence of trachomatous inflammation follicular (TF) in children 1—9 years of age was hyper-endemic (TF ≥30%) in 12 districts requiring 5 years of SAFE intervention. Furthermore, 19 districts were found to be meso-endemic with TF prevalence between 10%—29.9% requiring 3 years of SAFE implementation. The remaining 3 rural districts were confirmed as hypo-endemic districts with a TF prevalence of 5%—9.9%.

The result of the trachoma mapping has shown that active trachoma in children and potentially blinding trachoma in adults is a significant public health problem in the region. According to the mapping, over 4.4 million people are living in proven trachoma endemic areas of rural Tigray. Trachomatous trichiasis (TT), a potentially blinding complication of end stage trachoma of > 1% in adults greater than 15 years of age, is prevalent in 27 rural districts affecting 39,472 people; this means that the calculated ultimate intervention goal (UIG) for the region is 36,601 cases requiring surgical treatment.

Although, the existing allied eye care professionals in the region are qualified to carry out TT surgery, they had not undergone WHO’s certification process which ensures the quality of surgery. In order to fulfil this requirement, the regional health bureau sent two cataract surgeons to the federal ministry of health in Addis Ababa to be trained as training of trainers (TOT) and later to assist the master trainer during the refresher training in the region and carry out training themselves once they get sufficient experience.

Accordingly, 12 ophthalmic nurses were trained by Light for the World’s senior eye care advisor assisted by the two TOTs in the first round of certification in June 2015 in Mekelle, the capital of Tigray Region. The training was carried out over 5 days, of which one and half days were allocated for theoretical sessions, and another one and half days assigned to practice on HEAD START (Human Eyelid Analogue Device for Surgical Training And skills Reinforcement in
Trachoma); the remaining two days were spent carrying out surgery on live patients under the supervision of the trainers. Each trainee was expected to carry out correctly five eyelid surgeries on live patients to be certified. During the first round refresher training, 10 out of 12 ophthalmic nurses successfully completed the certification process.

An additional three rounds of refresher training was organised in the region and out of a total of 48 trainees, 44 of them were successfully certified. Five ophthalmic nurses and one optometrist failed to pass the certification process; these allied eye care professionals are currently working as assistants to the certified TT surgeons.

In addition to TT surgeon’s certification training, Light for the World’s Director in eye health/NTDs has also trained 14 supervisors for three additional days on supportive supervision skills. These trained supervisors are cataract surgeons, senior ophthalmic nurses and ophthalmic officers and provide regular onsite technical monitoring and support to the TT surgeons at the static and outreach sites using a supportive supervision checklist. During their visit issues such as patient screening, pre-and intra-operative procedures, medical waste management and infection control, proper documentation, as well as post-operative follow-up procedures and management of possible complications are assessed.

In addition to the supportive supervisors, Light for the World’s Director for Eye Health/NTDs has also been providing regular technical supportive supervision to the TT surgeons and supervisors at selected static and outreach sites. Based on skill gaps identified among the supervisors during his supportive supervision visits, he conducted three days of refresher training for all the supervisors in February 2017.

Between mid-2015 and the end of April 2017, a total of 22,105 persons have received TT surgery at static and outreach sites, compared to the calculated UIG of 36,601 for the region, meaning that out of the total UIG, 60.4% of the TT backlog has now been cleared.

In general, due to the TT surgery work in the region, the number of people seeking eye health services has increased at the community level. Furthermore, the blinding trachoma elimination plan has been successfully integrated and embedded within the existing regional government health system strategic plan. In order to clear the remaining TT backlog, the programme has to continue ensuring the active participation of various stakeholders such as political leaders, community networks for effective community mobilisation and increasing the commitment of TT case identifiers.
Implementation of Trachoma Mass Drug Administration

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According to the Global Trachoma Mapping Project (GTMP) 2013/14 survey, Ethiopia has the highest burden and prevalence of active trachoma globally. Around 557 districts are identified to be endemic for trachoma. Of these, 227 and 37 districts are from Oromia and Tigray region respectively, where Light for the World is supporting trachoma control projects.

Mass drug administration (MDA) using Zithromax and TTC is one of the components of the WHO recommended SAFE strategy to eliminate trachoma as a public health problem. The objectives of the project with regard to the MDA for trachoma are to support appropriate and quality mass drug administration in 42 trachoma endemic districts of Western Oromia zones to achieve the required coverage of over 80% and enhance internal capacity building for quality project implementation.

Capacity building is one of the major activities to ensure successful implementation of MDA. Training helps to improve the knowledge and skill of the internal staff members towards the implementation of the project. Quality training in how to dose the medication and proper logistics of an MDA to ensure availability of drugs in the right quantity at the right place and time contributes more than any other factor to the successful implementation of trachoma MDA. Taking this fact into consideration, the project undertook several cascading training sessions at different levels for different groups.

The Western Oromia zones trachoma project was launched in 2015. As the project was new for the area, it was mandatory to provide master TOT training for the NTDs focal person and the Oromia regional health bureau (ORHB) trachoma focal person from three trachoma endemic project zones at regional level for two days. Two individuals from each zone and ORHB attended the training. Additionally, Light for the World field project coordinators seconded to the zonal health department were also trained. A total of 11 people were trained to become master TOT trainers. These master TOT trainers in turn become trainers for zonal level TOT training attended by district trachoma focal persons. The trainers for this training were very experienced high level trachoma experts from Light for the World, International Trachoma Initiative and the Fred Hollows Foundation. At the zonal level, the trainees are district NTD focal persons who then become trainers for district level mass drug distribution team (health extension workers and community volunteers) and district MDA supervisors.

In 2015, during the first year of the project, zonal level TOT was conducted for 3 days. For the second round of trachoma MDA, one day refresher training was carried out. Besides zonal level TOT training, there was also a one day technical planning meeting, in which each district developed their own agreed upon implementation plan (micro plan). Thus, a total of 309 participants have attended from 41 districts in the two rounds of trachoma MDA.

As part of the launch during the first year of the project, regional and zonal level sensitisation and advocacy meetings were also arranged. All stakeholders and sectors in the region and zone who can contribute toward the elimination of trachoma participated in the meetings. A total of 26 participants attended the regional level and 102 participants attended the zonal level sensitisation and advocacy meetings. Additional sectors that participated included the education bureau, women and youth office, water and mineral offices.
Unlike that of onchocerciasis and lymphatic filariasis, which is handled by community volunteers, MDA for trachoma is managed by health extension workers (HEWs). This is because the drug for trachoma MDA (Zithromax) is an antibiotic and needs professional handling and management. The training for HEWs focuses on drug dosage determination, drug management, social mobilisation, reporting and recording.

A trachoma drug distribution team is composed of one health extension worker who is the team leader and three community volunteers, which share different shared roles. Of the three community volunteers at least two of them need to be able to read and write. One distribution team is expected to treat 2,000 to 2,500 people during the mass drug administration (MDA) week. HEWs are responsible for census data collection as pre MDA activity as well as dispensing the drug during MDA. So far, Light for the World has supported the training of 19,514 people (18,861 females and 653 males) as members of the trachoma MDA team during new and refresher training for the two rounds of trachoma MDA in 42 districts of the Western Oromia zones.

In order to ensure proper MDA and high treatment coverage, supportive supervision is a very crucial role in the performance of quality mass drug administration (MDA). Trachoma MDA supportive supervision is carried out at different levels using a standardised checklist during the three phases of trachoma MDA. The three common phases are pre-MDA, intra-MDA and post-MDA supportive supervision. There are 2 supervisors from the Oromia regional health bureau, 3 supervisors from the zonal health department and 940 district supervisors who are involved in the supportive supervision of trachoma MDA. There is also quarterly integrated supervision for health programmes in general.

Every year, the trachoma project plans to treat around 4 million people in 42 districts of the Western Oromia zones. During the first round of trachoma MDA around 3,651,645 (93.5%) people benefited from the project.
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