Vision & Development
Ophthalmology in Development Cooperation

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“Integration Buzz”?  

Development–Cooperation has a particular forte when it comes to creating buzzwords. These become holy grails—concepts that each and every programme should aim to achieve but which, through repetition, tend to lose their tangible meaning. “Integration”, alongside “Sustainability” and “Ownership”, has become one of those, as Chandhoke sympathetically calls them, “consensual hurrah-words”.

This edition of Vision & Development aims to give concrete examples of what integration can look like in practice in the eye health & NTD programming of Light for the World. We will look at integration of eye health in wider health programmes and tools such as primary and community health in Burkina Faso (page 8) and data collection in Mozambique (page 10). We will explore how specific areas of eye health can be integrated into each other, such as human resources and service delivery (page 6). In Uganda, will we explain how a whole programme can take integration as a principle (page 12). We will use integration to think how to better address neglected eye diseases like glaucoma (page 14) and observe the positive benefits of integrating antibiotic distribution for several diseases simultaneously (page 18). The edition also includes quotes from WHO’s Alarcos Cieza (page 5) and IAPB’s Peter Holland (page 17), showing how important Eye health Integration is to their respective organisations.

All these examples show, in my opinion, that integration is not something a programme has or doesn’t have. It’s not a tick-box. Integration considers every programme as a puzzle piece that only makes sense when connected to others, to create a meaningful picture. It’s a programmatic principle more than an end in itself. It forces us all to think beyond our silos. In times where health budgets remain precariously tight and development cooperation funding becomes more and more competitive, fostering integration of health programmes will continue to be a crucially important consideration.

We hope you enjoy reading the articles and putting meaning behind this buzzword!

Jess Blijkers
Interim Eye Health & NTD Director

We thank our partners!
“Integration must be THE central concept when we look at the future of Eye Health. Too long, we have considered Eye Health as a separate silo within in the health agenda. Within the current global context, we must do our utmost so that eye health is part and parcel of Universal Health Coverage. The World Health Organisation is pushing for eye health to be integrated in a variety of practical tools that are being developed to support Ministries of Health to move towards Universal Health Coverage. This includes tools to plan, monitor and evaluate human resources, assistive devices and equipment, service delivery, etc. The upcoming World Report on Vision will be a fantastic advocacy tool to support these integration efforts.”
The Gondar University Department of Ophthalmology and Optometry was established in 1982 as an academic centre. In 2006 the centre started training ophthalmic officers, cataract surgeons and optometrists. Currently the department is providing ophthalmology residency training.

Light for the World has been partnering with the University of Gondar since 2006 and supported the construction of an independent eye hospital with a capacity of 30 beds.

Alem Mekonnen, Programme Officer, Light for the World

The University of Gondar is the oldest medical school in Ethiopia, established as the Public Health College in 1954. It is located in Gondar, Amhara regional state of Ethiopia. Currently the University offers courses and programs leading to officially recognized higher education degrees in several areas of study. The University also owns a huge hospital, which serves a population of about 14 million with specialized health services. It acts as a referral centre for 8 general hospitals in the neighbouring zones.
The Hospital has a tertiary eye care centre with well-developed sub-speciality clinics such as oculoplasty, anterior segment, glaucoma, paediatric, and retina. The clinics are equipped with appropriate instruments and other supplies to serve as centre of excellence.

It also provides eye care services to the rural community through a regular rural outreach programme. From 2005 until the present day the centre has carried out about 76 outreach sessions.

As a tertiary eye care centre, it is also mandated to give ophthalmic training. Currently it has 255 students pursuing ophthalmic training at higher and middle levels, 21 of them are residents of ophthalmology. So far, 16 ophthalmologists graduated since 2012. In terms of its student population and its eye care service provision to the community, the University of Gondar tertiary eye care centre is one of the largest ophthalmic care and training centres in Ethiopia.

In 2017 the University of Gondar has signed a memorandum of understanding (MoU) with the Amhara Regional Health Bureau to place the newly graduated ophthalmologists in general hospitals to serve for 6–12 months. The aim of the partnership is to improve access to quality health care for the community by bringing qualified health personnel to the nearby hospitals.

The starting point for the partnership between the university and the regional health bureau was the patient overflow to the hospital because of the availability of quality and sub-speciality services. The catchment population preferred to be treated at the university hospital instead of at the nearby general hospital, which made the university hospital overloaded with cases that can be treated at a lower level of the health pyramid. Due to the lack of trained ophthalmic personnel, many cases that could have been treated at secondary or primary levels were referred to the tertiary hospital instead. This situation had the following implications:

- Patient overload and compromised quality of service at the university hospital.
- Long waiting list for patients including for those who needed urgent medical/surgical attention. This led to poor treatment outcome and created frustration for service provider and patient.
- Misuse of resources such as highly skilled ophthalmic team members treating minor cases that are supposed to be treated at lower level. The government was forced to subsidise tertiary level treatment costs which can be treated at secondary and primary level with minimum cost.

Due to these developments the University of Gondar took an initiative to integrate its human resource development programme with service provision in the catchment hospitals. Together with the regional health bureau they identified potential general hospitals by considering the number of catchment population, distance to Gondar hospital and geographic landscape of the surrounding areas. Based on the MoU, the Department of Ophthalmology assigned its newly graduated ophthalmologists to different secondary eye care units in the region. The university covers the salary of the ophthalmologists and the region covers their overtime/duty payments during their stay at the general hospitals.

THREE PURPOSES:

1. Making quality eye care services more accessible to the populations.
2. Improving referral linkages between secondary and tertiary hospitals.
3. Building local capacity.

The placement of new ophthalmologist in zonal/general hospitals make eye care services, including surgeries, geographically accessible and economically affordable for the community. The university also provides equipment and material support to the general hospitals by soliciting funds from various donors. The ophthalmologists do routine activities in the hospitals and do surgeries, mainly cataract, at outreach sites. The ophthalmic team in each hospital also benefits from skill transfer.

In future, the university plans to make those general/zonal hospitals clinical attachment sites for medical students by replacing the senior staff with final year students working under supervision. This plan needs huge financial investment and Gondar University is approaching its partners (governmental and non-governmental) to implement the plan as soon as possible.

The new initiative implemented by Gondar University and Amhara regional Health bureau can be taken as a good lesson. It helps the health system to function properly by managing appropriate cases at each relevant level and improves referral linkages between tertiary and secondary level. It prevents the community from unnecessary cost (time and financial) by availing the required services nearby. Finally, it also improves the quality of the human resources development programme by providing more immediate practical exposure for the freshly graduated ophthalmologists.
Integration into Primary and Community Health

Emile Rayaisse, Programme Officer Burkina Faso, Light for the World

Burkina Faso has a pyramidal health system that provides primary, secondary and tertiary health care. At primary level, the health districts have two levels: the Health and Social Promotion Centre (CSPS) and the Medical Centre with Surgical Capacity (CMA).

The CSPS is the basis of the health system and provides the minimum package of activities defined by the Ministry of Health. As a first point of contact between the population and the health system, it concentrates on prevention & promotion activities, as well as the care of the most common diseases. It is therefore essential to have well trained medical staff at this level of care for the management of priority diseases, including eye diseases. Many people suffer from eye diseases in Burkina Faso. According to the 2011 Rapid Assessment of Avoidable Blindness (RAAB) survey conducted in the Centre Ouest region, 8% of people over 50 are blind and 17% live with visual impairment.

It was on the basis of those results that the Ministry of Health of Burkina Faso, through its Directorate for the Prevention and Control of Non-communicable Diseases (DCDM), in charge of eye health, elaborated a project called “Eye Health Development in the Centre-Ouest region 2017-2019” (called “Pooni”, meaning “Light”, in local language).
This initiative is technically and financially supported by Light for the World and L’Occitane Foundation. The specificities of this project are the focus on primary & community eye health and the close alignment with the Ministry of Health’s 2016 – 2020 National Eye health Strategy.

Since the project relies heavily on training and awareness raising, the key was to take care of the issue correctly considering that in this health region, as in the whole country, there is not enough expertise for the management of common eye health conditions at primary and community levels. General nurses receive only 10 hours of eye health training as part of their basic instruction. Other professionals, such as midwives or itinerant health workers, who have an important role to play in eye health promotion, prevention and care, do not receive any initial training whatsoever on the topic.

EYE HEALTH TRAINING MODULES

When the project started, the Ministry of Health did not have any training materials on common eye diseases at primary and community level. Through a participative process in 2017, eye health training modules were developed 1) for non-specialised health workers (including nurses and mid-wives), 2) for community health workers1 and 3) for teachers. The process included Ministry of Health officials, eye health experts, the Directorate of Health Promotion (DHS) and other training institutions and actors. Ophthalmologists provided training of trainers to ophthalmic nurses, who in turn provided the training to non-ophthalmic health workers (nurses, mid-wives, etc) and teachers. The community health workers received training at district levels by head nurses supported by district management teams.

Once validated, the documents were made available to all stakeholders working in eye health. Although they were created with the Centre Ouest programme in mind, the ambition was that they become the Ministry of Health’s official modules for eye health training for primary and community health workers.

A progress report on the use of these national training modules has shown promising results for their appropriation by the different stakeholders. Already, as part of the implementation of the Regional Eye Health programme in the Centre Ouest Region, they have been used to train 120 primary health workers and 400 community health workers in the last quarter of 2018.

We were delighted that the modules are already “spilling-over” the Centre Ouest region. Indeed, other NGOs working in the field of eye health in other regions have used the modules in their programmes. For example, in the Boucle du Mouhoun region, CBM partners trained 80 non-specialist health workers and in the Cascades region, Sightsavers partners have trained 82 paramedic nurses from the 03 health districts with the same modules.

Six months after the training curriculum was validated by the Ministry of Health, a total of 682 primary and community health workers have been trained.

The Teacher Training Module will be piloted as part of the School Eye Health pilot project in the Centre Ouest region.

CONCLUSION AND OUTLOOK

The Ministry of Health of Burkina Faso now has standardised training modules for primary and community eye health, which is a fantastic step forward. They are intended for all eye health programmes of the Ministry of Health in Burkina Faso that have a primary or community component. A new Light for the World programme in the Centre Nord region will again be promoting the use of the training modules.

After one or two years of use, a review will be undertaken to ensure the modules still respond properly to the needs of the target groups. WHO Afro has recently launched the Primary Eye Health Manual, soon available in French, which will be another important resource to consider during the review process.

Advocacy is underway for the integration of the training modules into the curriculum of the training institutions, including the National Schools of Public Health (ENSP) and later in Teacher Training Institutes. This would be the next step towards full “Integration” ensuring increased capacities for eye health across the national territory.

Visible impact of Community Eye Health on service provision

In the Centre Ouest region mentioned above, we witnessed over the last years the incredible impact that Primary and Community Eye Health could have on the uptake of services by patients. Indeed, consultations and cataract surgeries were four times higher after less than 2 years! Consultations of children under 5 years of age increased by 600% in the same timeframe.
Integration in Health Information Systems

Sampaio Nunes,
Eye Health Programme Officer,
Light for the World

BRIEF HISTORY

In 2010, the Ministry of Health observed that the National Ophthalmology Programme\(^1\) was not using the standardised Health Information and Monitoring System (HMIS) in the country. There was no specific data collection tool for the programme, nor was the ophthalmology information part of the Electronic Data Collection System of the Ministry of Health.

This situation made it increasingly difficult to plan programme activities, because there was no official information regarding the eye care services in the country. To address this gap, a number of INGOs working in the sector at that time\(^2\) through the NGO Forum Mozambique Eye Care Coalition, decided to support the National Ophthalmology Program to design an adequate and integrated eye health information system.

\(^{1}\) The National Ophthalmology Program sits within the National Directorate of Medical Assistance (DNAM) and is part of the central organs of the Ministry of Health (MoH). Its main duties are: planning, setting standards and regulations for the eye health sector. At the provincial level, there are provincial eye care programs that branch out to districts where eye care services are available.

\(^{2}\) Dublin Institute of Technology, Ulls del Mon, Sightsavers, Hellen Keller and Brian Holden Vision Institute, HelpAge

SITUATION SURVEY

Initially a survey was conducted at the health units with ophthalmology services of Beira city and other provinces of the country. A lack of a specific tool to register patients in the ophthalmology consultations was observed. Each health unit applied another sector tool or used an ordinary book to collect the information. The data presented showed a huge disparity between the data collection instruments. Analysis, interpretation and dissemination at different levels were unmanageable.

Therefore, in 2012, during the preparations for the National Vision 2020 Planning Workshop, the Mozambique Eye Care Coalition formed a task group composed of Light for the World, the Dublin Institute of Technology and Ulls del Mon. This task group supported a number of provinces in filling in the IAPB data sheet to report collected eye health data. This data was the first comprehensive data collection in the country! It was then used as a situational analysis for the upcoming planning of a standardised Monitoring and Evaluation System.

ADVOCACY

Light for the World was appointed to design the required tools, including patient registration books and data collection sheets, for the different levels of service provision. All this was done in consultation with the representatives of the National Ophthalmology Programme and the National Directorate of Planning and Cooperation.

The International Agency for the Prevention of Blindness (IAPB) included Mozambique in their electronic information system, in the context of a larger EC-Funded-programme led by Sightsavers, in partnership with Light for the World and HelpAge.

DESIGN, VALIDATION, PRODUCTION AND DISTRIBUTION

The design of the data collection tools was based on the statistical model of IAPB that had been adapted to the Mozambican context by the Mozambican Eye Care Coalition (Light for the World, Dublin Institute of Technology and Ulls del Mon). The design is based on different record books of other health programmes. The monthly data sheet however was designed according to the main indicators defined by the National Ophthalmology Programme.

The tools were then presented at a national level. All technical and practical aspects, such as harmonisation with tools of other Ministry of Health programmes, levels of data collection and analysis, timing of submission, production and distribution were discussed and then revised for approval.

After the approval of the tools, the National Ophthalmology Programme requested Light for the World’s support to produce the instruments for the whole country. Thanks to funds from the European Union, led by Sightsavers (in partnership with Light for the World and HelpAge) sufficient data collection sheets and registration integration in health information systems.
INTEGRATING EYE HEALTH

Books were produced for and distributed to all health units with ophthalmology services in the country.

INTEGRATION INTO SISMA

The Health Information System for Monitoring and Evaluation (SISMA) has now replaced the former “Basic Module”. It was installed in all districts and big health units of the country and allows registered parties to access data from anywhere and at any moment via password. All paper-based information collected on health unit level are fed into this digital system. Training workshops on using SISMA and data awareness raising activities took place. Today the ophthalmology teams at all levels (national, provincial, district and health unit) know the importance of rigorous data collection, analysis and interpretation. The Monitoring and Evaluation System has been integrated successfully into the health system: the ophthalmic technicians use SISMA frequently and insert data monthly on district level.

CONCLUSION

Introducing eye health data into the national health information system is a lengthy process, which takes several years of continuing support, coaching and mentoring. Still, the low quality of the internet and the lack of computer skills by some ophthalmic technicians in the districts are restricting the full application of SISMA and the full utilization of collection data.

Nonetheless, this experience shows the crucial importance of integrating eye health into Health Management and Information systems and what a qualitative impact such a change can contribute in terms of planning, monitoring and evaluation eye health services.

Cataract surgeries increased by 80%

The data collection tools integrating eye health in Mozambique also allows Light for the World to show successes and increased outputs after long years of health system strengthening, cooperation with the health authorities and investment in human resources for eye health. Indeed, from 2017 to 2018 the number of cataract surgeries in the five provinces supported by Light for the World (out of Mozambique’s 11 provinces) increased by 80% from 2,315 to 4,125 cataract surgeries!

PLEASE SUPPORT people affected by Cyclone Idai in Mozambique!

On March 14th, 2019, Cyclone Idai hit Mozambique near Beira City, Sofala Province, bringing torrential rains and strong winds. President Filipe Nyusi has said the death toll in the country could be as high as 1,000. There are reports that 400,000 people have been made homeless, and countless families have lost all their belongings, crops, businesses, and thus their livelihoods. The port city Beira, where the storm made landfall and where the Light for the World office is based, is especially affected. Approximately 90 percent of the buildings in the city have been destroyed or damaged.

Light for the World is now tirelessly engaged in emergency response, ensuring persons with disabilities, who are particularly vulnerable, have access to the help they need. We are also ensuring, for example, that the Beira eye hospital, which was partially destroyed in the Cyclone can be reconstructed and made functional again.

Any financial support is welcome. www.light-for-the-world.org
Integration of Refractive Services & School Eye Health

Wolfgang Gindorfer,
Director of Uncorrected Refractive Errors and School Eye Health, and
Jess Blijkers,
Eye health Programme Manager, Light for the World

The National Intervention on Uncorrected Refractive Errors (NIURE) in Uganda, from the outset, was geared towards integration. Indeed, the overall objective of the programme has always been to show how refractive services and school eye health can be provided as part of a public health service in a Sub-Saharan African country.

From the very beginning, Light for the World and Brien Holden Vision Institute planned the programme together with the Ministry of Health, as a Ministry of Health programme. It was crucial to think of the long-term impact on patients’ care, and that, at a certain point in time, the programme activities would be part and parcel of the national stakeholders’ strategies and plans. As such, integration happened at all levels and on a variety of topics.

INTEGRATION OF SPECTACLE PRODUCTION

The central production of affordable, custom-made spectacles has been crucial for a nationwide service provision for patients who cannot afford spectacles from private entrepreneurs. By using a coded frame system, the OCO/Refractionists were provided with sample sets of frames from which patients can choose. OCOs then place the orders by phone, after which the National Optical Workshop, hosted within Entebbe General Hospital, produces and sends the spectacles to eye departments around the country within three working days.

In terms of integration, the Entebbe General Hospital Management gave physical space to the National Optical Workshop, storage rooms for frames and lenses, office space for the programme coordinator, etc. Financial aspects, including subsidised prices, cash-flows, etc, are governed by Ministry directive.

To further sustain the subsidised services, the Ministry of Health established a public-private-partnership (PPP) offering lenses and frames for the high-end clientele alongside those for patients in need. A newly established governing committee, called the National Optical Workshop Management Committee (NOWMC), oversees the management of the workshop.

INTEGRATION OF HUMAN RESOURCE DEVELOPMENT

Light for the World and Brien Holden Vision Institute jointly supported the development of the first optometry bachelor’s degree course (4 years) at Makerere University. A state-of-the-art optometry teaching lab and an Academic Vision Centre were established to ensure the best possible learning conditions for the students. The first batch of 5 students have graduated in January 2019 and became the first “home grown” Ugandan optometrists. To ensure the cadre is fully integrated into the health system, it has been necessary to initiate formal recognition of the optometry profession and to lobby for integration within public service. This is a crucial step to integrate optometrists into the eye health team and onto the government payroll.

Since 2017, 10 optometry students per year receive government sponsorship, which is a sign of the importance the Ugandan government gives to the profession.

With the vision of optometrists in sufficient numbers, skills and equitable distribution across the
country, we estimated that it would take at least a decade to both set up the course and provide a 4-year training to a tangible number of optometrists. We didn’t want to wait that long before providing services to the population. So, in parallel, NIURE offered a 6-weeks training course in objective and subjective sphero-cylindrical refraction to 74 Ophthalmic Clinical Officers (OCOs) based at Government health units. These OCO/Refractionists provide refractive services to populations throughout the country and are fully integrated within the health system.

INTEGRATION OF SCHOOL EYE HEALTH

A major component of the programme has been provision of School Eye Health activities. About 2 – 3% of children at school are estimated to have a refractive error significant enough to make spectacles necessary. With spectacles, the child can develop according to his or her individual potential. Without, he or she might not see what’s written on the blackboard or play ball games with others.

8 pilot districts were selected—through another directive of the Ministry of Health—to implement school eye health, outreaches and community dialogue. All materials used for teacher training and awareness raising were officially signed off by the Ministry of Health and sported the official logo. District education and health authorities selected the schools and communities that would benefit from the programme and spearheaded the activities. With different levels of commitment depending on the districts, activities have continued beyond the pilot phases.

Successful advocacy ensured eye health was integrated into the national school health policy. To create a lasting, countrywide impact, we are lobbying for school eye health to be taught as part of the teacher training curriculum. Teacher training curricula are only reviewed every 10 years and we aim for school eye health to be integrated at the next opportunity.

CONCLUSION

The NIURE programme in Uganda has shown that integration of refractive services and school eye health within the health system is possible and as such, is already a learning ground for other African countries. There might be short-cuts and “quick-fixes” to reach more people faster, but the long-term impact for the country and generations to come is only guaranteed through integration in and ownership of the national health and education authorities.

In January 2019, with great pride, Light for the World officially handed over responsibility of the NIURE programme to the Ministry of Health. This was not an after-thought, rather the ultimate objective that guided planning and implementation since the programme began 12 years ago.
Multi-disciplinary Collaboration for the Prevention of Glaucoma Blindness
INTEGRATING EYE HEALTH

Abeba T. Giorgis, MD, Associate Professor of Ophthalmology, Glaucoma Specialist, Addis Ababa University, Ethiopia

The words collaboration and integration refer to working together by joining activities and becoming one team with a common purpose. For early glaucoma case detection and prevention of irreversible glaucoma blindness, it is crucial to work together with already existing eye care and other health providers and programmes. This can be done through the integration and collaboration with the following health programmes:

CATARACT CAMPAIGNS AND OUTREACH PROGRAMMES

Cataract is still the most common cause of avoidable blindness in Sub-Saharan Africa. To reach people who do not have access to eye care services, many cataract campaigns and outreach programs are carried out, most of them with supportive or collaborative involvement of NGOs. During these campaigns and outreach programmes, hundreds, if not thousands, of people come for help. The examination usually contains measuring the visual acuity and checking the presence of a white (cataract) pupil by using a handheld torchlight and/or a magnifying loupe. So far it is not uncommon that cataract campaign employees send patients with impaired vision from glaucoma or other diseases back home, because of the absence of a white pupil, if it is a “one-disease-focused” campaign.

This should not be the case. Glaucoma can be integrated in existing eye health programmes. For instance, in Ethiopia, a national initiative called “National Cataract Backlog Clearance Initiative” is currently led by the Federal Ministry of Health (FMoH) and the National Committee for Prevention of Blindness (NCPB). Many other eye care NGOs, societies and stakeholders are involved.

This initiative includes strategies in which glaucoma detection can be easily integrated. For example:

- Enhanced regular outreach or campaign services. Different methods for the detection of glaucoma patients can be included. Such as: Measuring the intraocular pressure (IOP) using handheld devices, like Tonopen, I-Care or Schiotz tonometer and examination of the optic nerve head using direct ophthalmoscope.
- Establish efficient referral systems. If there is an efficient referral system for cataract, it will be much easier to detect and refer glaucoma cases as well.
- Increasing community awareness. Awareness about glaucoma in the population is generally low. Raising awareness for glaucoma has a key role on case detection, treatment, acceptance and adherence.
- Eye care integration into the existing health care. Integrating eye care into the existing resources and systems of health care could enable not only to detect and treat cases but also to provide efficient, accessible and affordable eye care services, including glaucoma.

TRACHOMA ELIMINATION PROGRAMMES

Africa is the worst affected continent when it comes to Trachoma. 29 countries are affected. Currently there are 31 countries (most in Africa) actively implementing the WHO recommended “SAFE strategy” (Surgery — Antibiotics — Facial cleanliness & Environment). The Trachoma elimination programmes are a huge opportunity to detect glaucoma as well. Awareness activities, case detection, and referral can be integrated with the already existing health education, mass drug administration, and trachomatous trichiasis (TT) case detection of the SAFE strategy. Those programmes can play a significant role in the

Glaucoma Toolkit

Light for the World, IAPB and ICO are currently collaborating on a “Glaucoma Toolkit” to provide guidance for medical personnel and programme staff around Glaucoma. A first version of the toolkit is planned to be released around World Sight Day 2019.
prevention of glaucoma blindness before trachoma is eliminated for good and the respective programmes are phased out.

**PRIMARY HEALTH CARE PROGRAMMES (PHC)**

Primary health care is a core policy of WHO to deliver basic health services at community level. It is the first level of contact between the individual and the health system. In Sub-Saharan Africa, Primary Health Care is not only accepted as part of many national strategies but also enables wide national coverage. In this kind of programme, health care is provided by suitably trained workforce supported by integrated referral systems. Primary health service includes health education, illness prevention, care, advocacy and community development.

The existing human power working at the primary health care level and the presence of primary health centres at community level, makes it possible and realistic to access communities in need of prevention of glaucoma blindness, alongside other eye diseases.

**NONCOMMUNICABLE DISEASE PROGRAMMES (NCDS)**

People affected by cardiovascular diseases (CVDs), chronic respiratory diseases (CRDs), cancer and diabetes are above the age of 40 years. This is also the population that is at high risk of glaucoma. The already existing presence of caring units starting from primary to tertiary hospitals make the integration of glaucoma detection within the NCDs feasible.

The existing human power working at the primary health care level and the presence of primary health centres at community level, makes it possible and realistic to access communities in need of prevention of glaucoma blindness, alongside other eye diseases.

**CONCLUSION: What do we need for collaboration and integration of glaucoma in existing health systems?**

1. Training of existing human resources on detection and treatment of glaucoma patients (Measuring Inter-Ocular Pressure, Assessment of the Optic Nerve Hypoplasia).
2. Provision of materials, devices and medication such as educational materials, Inter-Ocular Pressure measuring devices, visual acuity chart, direct ophthalmoscope, medication.
3. Guidelines on how to detect, treat, referral and follow-up a glaucoma case. (see info box page 15)
4. Ownership for the successful integration at continent, national and down to community level is required.

In conclusion, glaucoma blindness can be prevented by the integration of glaucoma awareness, case detection, early referral and follow-up systems to the existing health and eye care programmes.

**NEGLECTED TROPICAL DISEASE PROGRAMMES (NTDS)**

People who are most affected by NTDs are the poorest populations living in rural areas, urban slums and conflict zones. With no access to adequate sanitation and in close contact with infectious domestic livestock. Such people are also at high risk of being affected by blinding eye diseases, including glaucoma. Therefore, integration of eye care with the interventional activities of NTDs will be essential to prevent blindness.
INTEGRATING EYE HEALTH

Eye care needs to be integrated into mainstream health services as part of Universal Health Coverage. This means integrating eye care into primary care, strengthening and expanding eye health services at secondary and tertiary levels and ensuring eye care is funded as part of the essential package of services within any health financing arrangements. The IAPB alliance is committed to working with partners across health and other sectors to achieve Universal Health coverage and ensuring eye care is integral to Universal Health Coverage.

Peter Holland
CEO
International Agency for the Prevention of Blindness (IAPB)
Integrated Mass Drug Administration (IMDA)

in Ethiopia—Lessons and field practices on Neglected Tropical Diseases (NTDs)

Solomon Gadisa, Programme Officer; Adugna Amin, Programme Officer, and Dr. Amanuel Kidane, Tigray Regional Coordinator, Light for the World

BACKGROUND INFORMATION

Neglected Tropical Diseases (NTDs) are a group of chronic infectious diseases that inflict suffering and chronic disability on over 1 billion of the world’s most impoverished people. (The End Fund, 2016). The World Health Organization (WHO) globally classified 20 diseases as NTDs. While Ethiopia has identified and focused on eight priority NTDs for control and elimination (WHO, 2010), five require large-scale preventive chemotherapy (PC): trachoma, onchocerciasis, lymphatic filariasis (LF), soil-transmitted helminthiasis (STH) and schistosomiasis, and three NTDs require innovative and intensified disease management: dracunculiasis, leishmaniasis and podoconiosis.

Preventive chemotherapy (PC) is a package of activities for the mass distribution of drugs to the relevant target population. The package includes programme coordination, health education, advocacy, social mobilisation, census of target population, training, drug distribution, and Monitoring and Evaluation. There are variations in the type and number of the drug combination distributed at certain times, depending on the type of disease targeted, their co-endemism in a given region, the national goal and strategy.

An estimated 80 million people in Ethiopia live in regions where one or more NTDs are endemic. The government has led the national interventions scale-up to address the population at risk and to achieve Ethiopia’s NTD elimination and control targets by 2020. (FMOH, 2016–2020). (Belete Mengistu, March, 2016)

For more than a decade now, Ethiopia has been implementing NTDs prevention and control programmes in a vertical manner. This means that each disease was addressed separately. In 2017 Ethiopia introduced an integrated MDA (IMDA) programme implementation as a pilot initiative.
in selected districts of Oromia and Southern Nations, Nationalities, and Peoples’ Region (SNNPR). Since 2018 the second phase of IMDA has been enlarged by three selected regions, namely Tigray, Gambella and Benishangul-Gumuz. Learning from the pilot phases and with some changes, Ethiopia’s Federal Ministry of Health (FMOH) is planning to implement the Integrated Mass Drug Administration programme across the nation, starting from September 2019.

LESSONS AND FIELD PRACTICES FROM IMDA IMPLEMENTATION

1. The IMDA training manual enables provision of trainings and avoids duplication of training of the Health Extension Workers (HEWs).
2. Improved quality of training: The IMDA training manual was developed with clear objectives, standardised content and training duration for each level (region to district levels).
3. Introduction of a standardised supportive supervision in the IMDA: this helps to provide appropriate technical support and timely feedback.
4. Cost reduction: For example, the IMDA is using one integrated community registration book. As a result, the costs to produce disease specific community registration books were reduced. This is true for other costs of MDAs as well, for example, less post-MDA review meetings were needed.
5. IMDA strengthens the national health system and enhances local staff capacity building.
6. IMDA improves sustainability, ownership and community engagement.
7. Improves reporting quality: “One register, one report and one budget”.
8. The IMDA programme enables joint planning and intersectional collaboration. For example, from the education sectors, women and children’s offices, health offices etc.

CHALLENGES OBSERVED DURING IMDA IMPLEMENTATION

So far there were some challenges in the application of the integrated community registration book for IMDA. The reporting of the required variables and data was delayed and partly incomplete, which resulted in under or over reporting in some cases.

Another challenge was the coordination and delay in fund transfers. As the diseases previously addressed separately also had different sources of funding, it was a real challenge to align and coordinate the budget transfers from the different sources.

ACHIEVEMENTS AND CONCLUSION

So far the IMDA was successfully implemented in 31 districts of the Tigray region, and IMDA training was conducted in 83 districts of Western Oromia. Integration was done in all MDA programme implementation cycles, including joint planning meetings, trainings, mass drug administration, supportive supervision, social mobilisation and post MDA review meetings. The IMDA covers all preventive chemotherapy targeted NTDs, including Schistosomiasis and soil-transmitted Helminthiasis.

In 2018, a total of 4,164,394 (Tigray region) and 10,412,636 (Oromia region) people were treated for Trachoma, Onchocerciasis and Lymphatic Filariasis by IMDA and coordinated MDA in Light for the World supported areas.

Learning from such experiences of integration will be crucial moving forward, as the need for coordination between actors and funding sources, ownership of Ministries of Health, efficient use of available funds and effective community mobilisation will become paramount principles for NTD programming.

DISCLAIMER:

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