TRACHOMA SAFE STRATEGY SERIES:
Surgery

Transition planning for trichiasis management services

Transitioning trachomatous trichiasis (TT) management from dedicated service delivery activities into a routine eye health care system

ICTC International Coalition for Trachoma Control

Acknowledgements

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Front cover: William Nsai

Foreword

This toolkit for transition planning is one of three planning documents recommended by the International Coalition for Trachoma Control for program managers and implementing partners to support transition from elimination efforts (public health interventions) to routine public services. The importance of effective leadership underpinning the success of these programs cannot be overstated.

The series of transition toolkits include:

- Transition planning for trichiasis management services
- Transition planning for mass drug administration of Zithromax®
- Transition planning Facial cleanliness and Environmental improvement

These toolkits can be used in a variety of ways: (i) as a step-by-step planning guide (ii) as a checklist to ensure planning is on the right path (iii) as a reference document on key planning components and (iv) to engage non-trachoma partners in the planning and delivery of transition activities.

A last check for trachoma in Nepal: Bishal Dhakal, Trachoma Grader, checks the eye of Jyoti Rayamajhi, a female community health volunteer. Photo: RTI International/ Nabin Baral

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Background

The Global Alliance for the Elimination of Trachoma (GET2020) established the year 2020 as the target date for eliminating trachoma as a public health problem, at the first global scientific meeting in June 1996. Eliminating trachoma as a public health problem has three criteria, which are (1) a prevalence of trachomatous inflammation—follicular in 1–9-year-olds of <5%, sustained for at least two years in the absence of pressure from antibiotic mass drug administration, in each formerly endemic district; (2) a prevalence of trachomatous trichiasis (TT) unknown to the health system in ≥15-year-olds of <0.2% in each formerly endemic district; and (3) written evidence that the health system is able to identify and manage incident TT cases, using defined strategies, with evidence of appropriate financial resources to implement those strategies. Criteria (2) and (3) are pertinent to the current document.

When an impact, surveillance or TT-only survey indicates the district prevalence is below the TT elimination threshold, dedicated case finding and outreach services can be discontinued. Rather than finding cases and treating them during campaigns supported by external partners, ongoing TT management services (for incident or post-operative cases) and any remaining cases would be provided through routine eye health care services offered at district level health clinics. Experience suggests that new cases of trichiasis attributable to trachoma, although few in number, are likely to develop for many years after elimination targets are reached. This system is needed to fulfil the requirements of criterion (3) for validation of elimination.

NGO partners play an important role in assisting communities and district, regional and national authorities in preparing for TT management to be carried out via routine eye health care services once the WHO TT elimination threshold has been attained. Local capacity development, mainstreaming and institutionalizing quality TT services as integral part of eye health should start as early as possible (ideally at the design stage) and continue throughout the program.

Linking trachoma elimination to wider development goals: Program activities and the planning and execution of the transition of TT surgical responsibilities to the national health system will directly contribute to the Global Surgery 2030 Goals[1] while also furthering Universal Health Coverage (UHC) through quality, availability, accessibility and readiness for surgery[2]. Effective transitioning work will directly contribute to Global Surgery Goal indicators 1, 2, 3, 5, and 6 below:

1. Access to timely essential surgery: the geographic accessibility of surgical facilities.
2 Specialist surgical workforce density: the density of specialist surgical providers (surgeons, anaesthetists, and obstetricians).
3. Surgical volume: the number of surgical procedures provided per 100,000 population.
4. Perioperative mortality rates.
5. Risk of impoverishing expenditure: the risk of impoverishing expenditure when surgery is required.
6. Risk of catastrophic expenditure: the risk of catastrophic expenditure when surgery is required.

It is recommended that 'transition planning' is incorporated during the development of the national Trachoma Action Plan. Countries that do not have a detailed transition plan should start the process of developing a plan as soon as possible. Involving the MoH eye care directorate/unit in planning is essential. The following steps will guide both ministries and NGO partners in the essential activities to support a successful transition.

1 In January 2014, Dr Jim Kim, President of the World Bank Group, challenged The Lancet Commission on Global Surgery (LCoGS) to develop consensus-based indicators and time-bound targets to track progress. In April 2015 the Commission recommended six core indicators to assess surgical and anaesthesia systems strength. Considered together, they serve as basic proxies of surgical health system functioning. https://gh.bmj.com/content/2/2/e000265#ref-3

2 The United Nations resolution on Universal Health Coverage was unanimously adopted on 12 December 2012. The resolution urges governments to provide all people with access to affordable, quality health-care services – this includes management of TT.

Steps in planning

Step 1: National level: Advance communication triggering district-level transition planning

Ideally, the 'transitioning' process can begin at the same time a trachoma program launches. While the ministry of health is engaged in honing the in-coming support of various implementing partners to address all aspects of the SAFE strategy, efforts could be made to develop timelines and processes that would define when and how the ministry of health (and other ministries) could fully absorb both the financial and logistical aspects of the program. Many national programs are well along their way toward elimination while a few others have already crossed the line. Accordingly, a process for transitioning needs to be a facilitated discussion and customized to each country's current position.

The ministry of health, with the assistance of other key ministries and stakeholders, should consider conducting a national-level meeting to assess the current status of TT integration, exploring the following:

a. Which TT management related activities are already integrated into the health system?
b. Which activities, currently underway, will need to be maintained post-validation and for what period of time?
c. Which institutions/agencies would each of these desired activities be responsible and maintained?
d. What additional activities currently not (or never) supported need to be reintroduced and supported into a fully transitioned program?
e. What new (additional) stakeholders could be engaged to carry out some of these activities?

This meeting should also be used to inform key stakeholders about transition planning components, ensure that everyone has the various templates and the draft fact sheet (see under ICTC resources on **www.trachomacoalition.org**) and provide guidance on how to proceed at the regional/district level.

Planning for formal transition should be organized in close collaboration with the general eye health services nationally, with micro-planning and implementation undertaken district-by-district/region-by-region. National guidance is required. Clear communication from the national to the regional and district level will likely lead to greater prioritization of this activity. As there are likely to be contextual differences district-by-district/region-by-region communication from the national level should serve as a guide and be adapted where necessary.

District, regional and national level authorities need to have the necessary **knowledge** and **evidence on trachoma elimination** to ensure a smooth transition.

Additional information and considerations: Achievement of trachoma elimination at the district level needs to be celebrated. That said, elimination may not be "forever"; sustaining elimination through strong general eye health services and supporting transition through local capacity development, mainstreaming and institutionalization requires advocacy, resourcing and communication. Clear communication to all stakeholders is essential.

Table 1

Planning decisions / suggested activities	Supporting documentation	Responsible	Scheduled date of completion	Status	Comments
1. Conduct national level meeting with key stakeholders to review transition planning and explore the potential approaches to transition planning given the context at the regional and district level.	WHO validation guidelines; National prevention of blindness or eye care plan(s)				
2. Communication from national level health ministry to district and regional authorities to trigger the transition planning process.	District level prevalence data District level supporting documentation regarding historical TT management services delivered, outputs and outcomes attained Dates for next scheduled prevalence survey	National health ministry with assistance from coordinating partner			
3. Assist (as indicated) with the organization of a district-level transition **planning meeting** with all relevant stakeholders. *See Annex 1 for suggested draft agenda*					
4. Determine if it would be appropriate to include TT in the national surveillance system or HMIS.					

Step 2: District level planning for the provision of TT management services through the routine eye health care system (or other systems as defined by the MoH)

The district level transition plan lays out how existing personnel, instruments, and (routine) eye care activities will be utilized to continue to provide TT management – from identification/referral through to case management including follow-up. Monitoring and reporting through existing systems to national level will also need to continue even after WHO TT elimination threshold has been attained. While it is recognized that each district-level transition plan will be based on the local context, the transition plan should include, but may not be limited to, the following and plans need to be developed with persons responsible for the agreed upon system for provision of TT services:

1. Listing of trained and experienced surgical team personnel – and where they are located - within the district (or which can provide services to the district).
2. Identification of primary sites for providing TT management services.
3. Inventory of surgical equipment, instrumentation and consumables at each primary site for TT management services.
4. Agreed process for:
   - ✓ TT case identification and counselling.
   - ✓ Scheduling of TT service provision.
   - ✓ Referring cases for specialized treatment (post-operative TT, lower lid TT, TT in people under 15 years of age, etc).
   - ✓ Logistical support to identified TT patients (to receive services and post-operative follow-up) if needed.
   - ✓ Supportive supervision to TT surgeons and surgical teams.
   - ✓ Upgrading skills in case finding and provision of TT management services, if needed.
   - ✓ TT post-operative follow-up, including assessment of surgical outcomes.
   - ✓ TT data capture and reporting, including post-operative follow-up to assess surgical outcomes.

Table 2

Planning decisions / suggested activities	Responsible	Scheduled date of completion	Status	Comments
1. Undertake an assessment of current (routine) eye care services at the district level (to aid TT services to be embedded in routine eye care activities). *See Annex 2 for the suggested checklist*				
2. Create a list of people who refused surgery over the past year. If TT is below WHO threshold for elimination (0.2% in age group 15 years and above) the number of new cases will likely be small; still, expect to have 20 or more people per year to present for surgery. Use these figures to estimate consumable needs.				
3. Take stock of consumables remaining from the active outreach program; there may be a need to transfer some instrumentation and consumables to districts with inadequate supplies.				

Table continues on next page

Table 2 (continued)

Planning decisions / suggested activities	Responsible	Scheduled date of completion	Status	Comments
4. Determine situations in which a visiting surgical team could be used.				
5. Determine organization of static services (e.g. specific days for surgery or on-demand?)				
6. Determine how TT surgeon skills will be maintained.				
7. How will supportive supervision be provided to TT surgeons? Determine if surgical audit (by supervisors) of selected TT surgeons will be undertaken; if undertaken, create a schedule.				
8. Determine management of post-operative TT or lower lid TT and create a mechanism whereby people identified with post-operative TT or lower lid TT are referred for expert care.				
9. Determine how routine follow up will be organized (at static site or by other methods) and if services (e.g., transport) will be provided for patients to receive TT management.				
10. Determine (if indicated) what will be the most effective and efficient method(s) for informing patients of where services can be obtained.				
11. Provide health workers with information (handouts) on TT and referral, if needed.				
12. If routine eye care outreaches are planned, determine how TT patients will be identified and managed within the outreach.				
13. Determine how consumable and instrument needs will be incorporated in the district medical supply procurement system.				

Step 3: Plan for field data capture, reporting and analysis to inform decision-making

A successful transition should lead to validation of elimination of TT and confidence that all patients with TT are being managed properly. For that reason, careful documentation and reporting are essential. Documentation of services provided (post elimination) is critical for preparation of the national dossier and for identifying any problems

Trainers and a local resident discuss Tropical Data during a field practice. Photo: Shea Flynn/International Trachoma Initiative

Table 3

Planning decisions / suggested activities	Responsible	Scheduled date of completion	Status	Comments
1. Review of current data collection tools and systems; revise, as needed.				
2. Provide, if necessary, capacity to relevant health personnel on data to be collected, reasons for collection, and how data will be used.				
3. Determine where TT surgical registers will be kept.				
4. Determine how information about cases identified and referred will be communicated to relevant health authorities.				
5. Ensure that, at national level, data flow and compilation continue.				

Annex 1. Suggested agenda at initial district-level transition planning meeting

- Overview of WHO guidelines for elimination of trachoma as a public health problem (and the concept of transition to management through routine clinical services).
- Overview of history of trachoma in the district (including data from all surveys).
- Recent history of activity (last three years).
- Discuss likelihood and number of incident, remaining and recurrent cases – people to understand the nature of the disease.
- Discuss the national plan for how TT services are to be integrated into general eye health care or other health ministry systems and then discuss how it can be carried out at the district level.
- Identify the point person for trachoma services at all relevant administrative levels (district, regional and national).
- Confirm the national roles and responsibilities at all administrative levels – from national to district authorities in communication with district authorities.
- Review the National Elimination Dossier and how the district work contributes to that.
- Agree on the aspects that need to be reviewed and plan for the district level assessment of service. These will include:
  - Identification of surgical site(s);
  - Resources available in each district (particularly TT eye surgeons competent in TT, supervisors, consumables and instruments);
  - Determine if any capacity building is needed and develop strategies for systematic and where required, targeted eye health system strengthening (including adequate budget allocation);
  - Confirm data collection and reporting procedures fully integrated into the HIS at all levels;
  - Review the capacity of health system for transport or linkages to any transport system in place for cataract patients and communicate transport plan to relevant health providers.
- Plans for district/regional/national celebration acknowledgment of success towards achieving of elimination.

Annex 2: Checklist for assessment of eye care services to embed TT services

The checklist below reflects the typical resources required in order to be able to offer TT management services. It is assumed that these resources are part of – and/or can readily be accessed by – the district-level routine eye care services.

Item	Health facility (non-surgical)	Y/N?	Surgical site/facility	Y/N?
Personnel	Frontline health facility workers (one or more who are able to identify trichiasis)		Eye surgeons competent in TT surgery (including contact details)	
Equipment (to be available within the district)	■ Magnifier for assisting with examination of eyelids		Eyelid TT surgery surgical sets (to include adequate and functioning): ■ Number of full TT surgery instrument sets; if partial sets, identify missing items and ensure availability of BLTR clamps / Trabut plates (as per preferred technique). ■ Develop a plan and budget for replacement.	
	■ Torchlight for examining eyelids		■ 2.5 x loupes for surgery ■ Good theater lighting	
			■ Sterilization equipment (i.e. stove and sterilization pot)	
Consumables	Tetracycline eye ointment and / or local Azithromycin eye drops (both are part of the WHO essential drug list)		Eye surgical consumables to include sufficient: ■ Gauze ■ Cotton wool ■ Suture (4/0 silk or 5/0 Vicryl with 3/8 circle reverse cutting needle) ■ No 15 surgical blade ■ 5cc syringe with needle ■ Povidone iodine ■ Alcohol 70% solution ■ Surgical masks ■ Sterile surgical gloves (sizes 6-8) ■ Surgical drapes with 6cm X 6cm hole ■ Zinc strapping ■ Surgeons caps Post-OP: ■ Paracetamol tablets ■ Tetracycline eye ointment, ***or*** — AZM eye drops, ***or*** — Zithromax tablets	
Records	■ Outpatient Department (OPD) ■ Referral slips		■ Outpatient Department (OPD) Register ■ Operation register ■ Eye (lid) surgery reporting / data to include TT surgery in district HIS	
Capacity strengthening	■ System-level		■ Lid surgery training, supportive supervision and monitoring and evaluation (including TT surgery)	

International Coalition for Trachoma Control (ICTC)

VISION:
Global elimination of trachoma as a public health problem 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

www.trachomacoalition.org | trachomacoalition@gmail.com