Sightsavers

Elimination of Blinding Trachoma

Ten-year strategic fast tracking plan in 24 countries – November, 2011

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15 November 2011

Registered charity numbers 207544 & SC038110

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Acknowledgments

This document has benefited from the technical expertise and well thought through inputs from many people. Dr. Silvio Mariotti, (World Health Organization), Dr Danny Haddad, (Director, International Trachoma Initiative) and Dr. Awad Hasan Ahmed (Trachoma Programme Coordinator Republic of Sudan) made very useful contributions to this document.

I would also like to make special mention of Dr. Hannah Faal for her immense contribution in reading the document thoroughly and providing very useful guidance in the writing of this document.

My sincere thanks go to Caroline Harper, Chief Executive Officer of Sightsavers for conceiving the idea of a fast track initiative to eliminate blindness due to trachoma and actually ensuring that it is birthed and nurtured and for encouraging us to think more broadly and include as many countries as needed in this fast track initiative.

I thank all other Sightsavers staff especially the Strategic Management Team including Adelaide Addo-Fening, Director of Programmes and Dominic Haslam, Director, Policy and Strategic Programme Support for their inputs, encouragement and total support for the fast track initiative.

To Benedict Hoefnagels, Elizabeth Elhassan, Ronnie Graham and Nancy Thuo, I say thanks for their time spent in reviewing and contributing to the document.

This document could not have had reliable data without the contributions of our Country Directors. I would like to make special mention of Sunday Isiyaku, Joseph Oye, Niaz Ullah Khan, Joyce Ashun, Joseph Munsanje and Ben Male.

To Rose Sedjro, Team Administrator for Advocacy and African Alliances: I thank you for your excellent support and encouragement. Your support is phenomenal.

To Simon Bush, Director, Advocacy and African Alliances, my line manager, I would like to say a very special thanks to you for your confidence in me. This document is your document – you thought through carefully, gave the ideas, the directions, read through every draft, edited and gave excellent feedback whilst you cheered me on to complete this work. I am forever grateful.

Any errors or omissions are my responsibility.

Dr. Agatha Aboe
Global Trachoma Programme Coordinator

15 November 2011

Abbreviations and acronyms

BH	Borehole
BTRP	Bilamellar Tarsal Rotation Procedure
CAR	Central African Republic
CBOs	Community Based Organizations
C4D	Communication for Development
DANIDA	Danish International Development Agency
DDHS	District Director of Health Service
DFID	UK aid from the Department for International Development
DHMT	District Health Management Team
GET 2020	Global Elimination of Blinding Trachoma by 2020
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HKI	Helen Keller International
HMIS	Health Management Information System
ICTC	International Coalition for Trachoma Control
IDSR	Integrated Disease Surveillance and Response
IE&C	Information, Education & Communication
INGDOs	International Non Governmental Development Organizations
ITI	International Trachoma Initiative
MDA	Mass Drug Administration
MDGs	Millennium Development Goals
MOH	Ministry of Health
N/A	Not Applicable
NGO	Non Governmental Organization
NTDs	Neglected Tropical Diseases
OCP	Onchocerciasis Control Programme
ON	Ophthalmic nurse
OPC	Organisation pour la Prévention de la Cécité
PHC	Primary Health Care
PRA	Participatory Rural Appraisal
RTI	Research Triangle Institute International
SAFE	Surgery, Antibiotics, Facial cleanliness, Environmental improvement
SWOT	Strength, Weakness, Opportunity, Threat
TF	Trachoma Follicular
TT	Trachomatous Trichiasis
UIGs	Ultimate Intervention Goals
UNICEF	United Nations' Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Trachoma is the leading cause of preventable blindness in the world. In 2003 WHO estimated that 84 million people were suffering from active trachoma, 7.6 million people are visually impaired or blinded as a result of trachoma.[1] Population-based surveys provided recent information for 42 out of 57 endemic countries. 40.6 million people are estimated to be suffering from active trachoma, and 8.2 million are estimated to have trichiasis.[2]

Overall, Africa is the most affected continent; 27.8 million cases of active trachoma (68.5% of all) and 3.8 million cases of trichiasis (46.6% of all) are located in 28 of the 46 countries in the WHO African Region, with an estimated population of 279 million living in endemic areas.[3]

The World Health Organization (WHO) made a call in 1997 for a Global Elimination of blinding Trachoma by 2020 (GET2020) and endorsed a strategy – SAFE. [4]

SAFE stands for:

Surgery	-To correct in-turned lashes.
Antibiotics	-To treat active infection, using Azithromycin.
Facial Cleanliness	-To reduce disease transmission through face washing.
Environmental Improvement	-To increase access to clean water and improve sanitation to facilitate disease elimination.

WHO has defined elimination of blindness due to trachoma as:

The prevalence of active trachoma TF is less than 5 percent among children aged 1 to 9 years old and prevalence of trachoma trichiasis is less than 1 case per 1000 population.

The global efforts to eliminate blindness due to trachoma have been on-going and with just about 10 years to reach the global deadline, the International Coalition for Trachoma Control[5] (ICTC), of which Sightsavers is a member, has developed a plan to increase the efforts being made to ensure that the goal of GET2020 is met. A document, 2020 INSight has therefore been written by the partners of this great coalition to guide members and endemic countries as to the overall global need, how to address this need and the resources needed to reach our goal. Sightsavers has responded to this call through this Fast Track Initiative and has taken up the challenge to catalyze, support and fast track the elimination of blinding trachoma in 24 countries; 22 in Africa (including Chad and Central African Republic through partnership with the Organisation pour la Prévention de la Cécité – OPC) and in 2 countries in Asia, India and Pakistan.

Programme Goal

To fast track the elimination of blinding trachoma in 24 countries; 22 in Africa and 2 countries in Asia - Pakistan and India by 2020.

Strategic Direction

The strategic direction for fast tracking the elimination of blinding trachoma from the target countries is based on the Sightsavers new Strategic Framework of Health Systems Strengthening, demonstrating scalable interventions and working in strong partnerships with governments and non-governmental organisations, communities and other stakeholders for rapid scale ups of interventions and eliminating the disease in these countries by 2020. For trachoma control, the SAFE strategy has been piloted and demonstrated in many countries. This programme will therefore seek to take projects into the next stages of marketing,

and building up partnerships, implementing the three components of policy change, expansion and replication to achieve the scale up required.

Outcome Objectives

1. To reduce the prevalence of active trachoma (TF) to less than 5% among children aged 1 to 9 years.
2. To maintain TT recurrence below 10 percent.
3. To reduce the prevalence of trachomatous trichiasis (TT) to less than 1 case per 1000 population above 15 years old.

Output Objectives

1. To conduct baseline surveys in 753 trachoma endemic districts in 24 countries.
2. To conduct impact surveys in 727 programme districts in 24 countries.
3. To conduct surveillance surveys in 727 programme districts on reaching their ultimate intervention goals.
4. To provide support to 10 countries to develop a multi-year strategic plan document for the elimination of blinding trachoma.
5. To provide surgery to at least one-third of the estimated number of about three million (i.e. one million) TT patients in the Sightsavers supported countries by 2020.
6. To train and retrain and certify 1800 TT surgeons- at least 2 surgeons per programme district.
7. To train 14,000 health workers (20 per district) and 140,000 volunteers (200 per districts) to identify and register TT cases.
8. To expand antibiotic distribution to 84million people, covering all endemic districts (about 700 districts) and communities in the 24 countries and achieve a coverage of at least 85-90% of the eligible population.
9. To train 28,000 health workers (40 per district) and 280,000 volunteers (400 per district) to distribute antibiotics, monitor for any adverse events and provide behavioural change education to endemic communities.
10. To have at least 80 percent of children 1 to 9 years old with clean faces in the endemic communities in the target countries.
11. To intensify advocacy toward increased access to water by about 20% and sanitation by about 30% in all endemic communities in the target countries as a human rights issue. (10,000 safe water sources and 100,000 household latrines provided).
12. To conduct both basic and operational research to enhance learning and provide evidence for elimination.
13. For any innovative approaches, to use the scalability principle, that is, to pilot projects, provide evidence, make reality adjustments, and build capacity and partnerships for scaling up.

The objectives and activities for the SAFE strategy for the countries as well as the outcome and output indicators have been put in a Logical Framework and attached.

Programme Areas

In the next 10 years-2011-2020 the programme is expected to cover all 24 countries; 22 in Africa and 2 countries in Asia- Pakistan and India. The countries in Africa are Benin, Burkina Faso, Cameroon, Ghana, Guinea (Conakry), Guinea-Bissau, Kenya, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal, South Sudan, Sudan, Tanzania, The Gambia, Togo, Uganda and Zambia. The programme will also provide some support to Chad and Central African Republic through a partnership with Organisation pour la Prévention de la Cécité (OPC).

A total of 84million people from about 700 districts in the 24 countries are expected to benefit from this initiative.

Period Covered

The strategy covers a period of 10 years-January 2011 to December 2020.

Programme Activities

Sightsavers will work with governments and other NGOs to strengthen the health systems based on a primary health care approach through training of health care staff at the district, sub-district and Community-based Health Planning and Services (CHPS) Initiative zone (in the countries in which CHPS exists) levels. Guidelines for delivering primary eye care services using basic and appropriate equipment and tools will be provided.

Community-based activities will be integrated into the primary health care system and structure. However, it is also worth mentioning that for an elimination programme there would be the need for vertical programme implementation such as training of TT surgeons and actual provision of surgery to people with TT and some related research activities. Implementation of advocacy activities may be by both horizontal and vertical means. The level of Sightsavers support in a particular country at any particular time will be based on need, political will, government efforts and support by other NGOs. Governments and other stakeholders will be encouraged to take control activities to full scale to reach their ultimate intervention goals (UIGs).

Partnership

It is expected that governments-especially the Ministry of Health of the countries will play the leading role and serve as the overall coordinator for the country programmes. Sightsavers will work in partnership with governments-bilateral and country and international and local non-governmental organisations as well as firms in the private sector to achieve these objectives. Sightsavers will work very closely with WHO and other multilateral organizations to ensure that WHO guidelines and international standards are followed for quality programme implementation. List of current and potential partners and their roles have been outlined in the document. Multi-country meetings with all partners will be held annually or biennially to enable sharing of best practices, challenges and solutions as well as helping in making policies to guide the programme.

Programme Costs/Support

An estimated budget for the 10 years has been worked out. The budget includes the components of the SAFE strategy but excludes the cost of Azithromycin because it is expected that Azithromycin will be provided free by Pfizer through the International Trachoma Initiative/The Task Force for Global Health. The administrative costs have also been worked out.

The total cost for “SAFE” and administration without the provision of water and latrines is $190million for ten years with an average cost of $19million per year.

The unit cost per surgery is $40.00 and the unit cost for the distribution of antibiotics comes to $0.25. Sightsavers will make advocacy to partners to support in the provision for safe water sources and latrine construction. The cost for the construction of these has been worked out for the benefit of our partners in this sector. It is expected that out of this advocacy, the programme will contribute about $5,000 per district per year towards facial cleanliness and $20,000 per district per year towards environmental improvement. Details for budget breakdown for each year will be outlined when an annual implementation plan is drawn. It is expected that through the efforts of advocacy and fundraising Sightsavers would be able to attract partners and potential partners to commit to this strategic document to ensure that we deliver on this task that we have set ourselves.

1.0 Introduction

1.1 Background

Sightsavers' vision is of a world where no one is blind from avoidable causes and where visually impaired people participate equally in society. This vision fits very well into the Global Vision, Vision 2020: the Right to Sight.

Trachoma is the leading cause of preventable blindness in the world. According to WHO, 84 million people are at risk of getting trachoma, 8.0 million people are visually impaired from trachoma and about 1.3 million people are known to be blind because of trachoma.

Trachoma is a disease of the poorest of the poor and those who are deprived of water and sanitation and is thus common in developing countries. Repeated infection over a number of years can lead to scarring of the conjunctiva. The disease spreads easily from person to person primarily from child to child and to the child care-givers, usually women. Trachoma begins in early childhood and progresses over the years as episodes of re-infection cause inflammation and scarring of the conjunctiva. The scarring causes the upper eyelid to turn inwards, thus causing the eyelashes to rub on the cornea (cicatricial trachoma). This in turn results in corneal abrasions, corneal scarring, opacification and ultimately blindness usually at age 40 years and above although trachoma blindness has also been seen in people much younger.

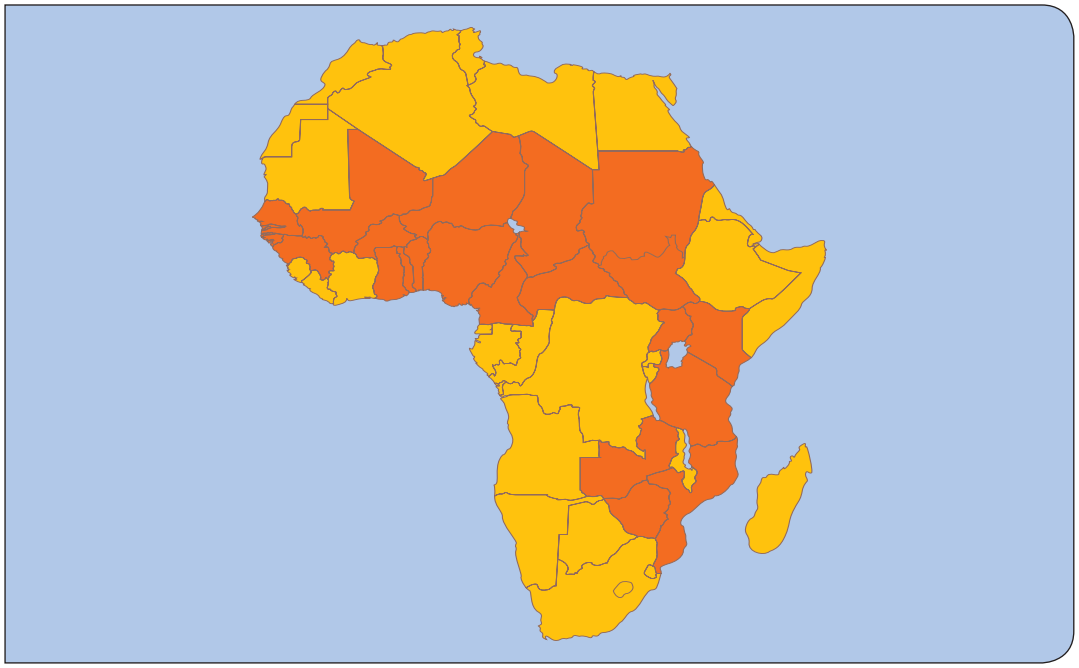
WHO made a call in 1997 for a Global Elimination of blinding Trachoma by 2020 (GET2020) and endorsed a strategy called SAFE. **SAFE** stands for:

Surgery	-To correct in-turned lashes.
Antibiotics	-To treat active infection, using Azithromycin.
Facial Cleanliness	-To reduce disease transmission through face washing.
Environmental Improvement	-To increase access to clean water and improve sanitation to facilitate disease elimination.

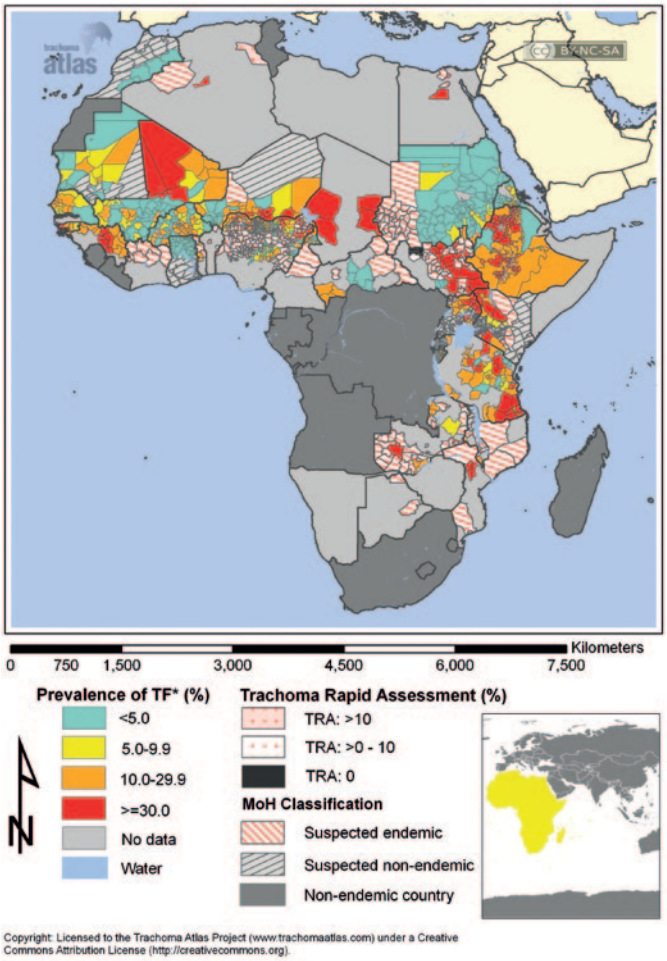
Since this call, many stakeholders have heeded to the call in providing drugs, funds and technical support for implementing the WHO endorsed SAFE strategy for the control of trachoma. The UN General Assembly in July 2010 passed the resolution that access to clean water and sanitation is a human right[6]. Elimination of blindness due to trachoma has been demonstrated and achieved in Morocco and other countries. Ghana and The Gambia are also on her way to achieving elimination.[7]

Sightsavers has been working in 35 countries in Africa and Asia to meet the goals of Vision 2020. Although some work has been done in the implementation of the SAFE strategy in many countries only a few have reached the elimination stage or close to the elimination stage. Sightsavers has therefore taken up the challenge to catalyze and support fast track the elimination of blinding trachoma in 24 countries; 22 in Africa and in 2 country in Asia, India and Pakistan.

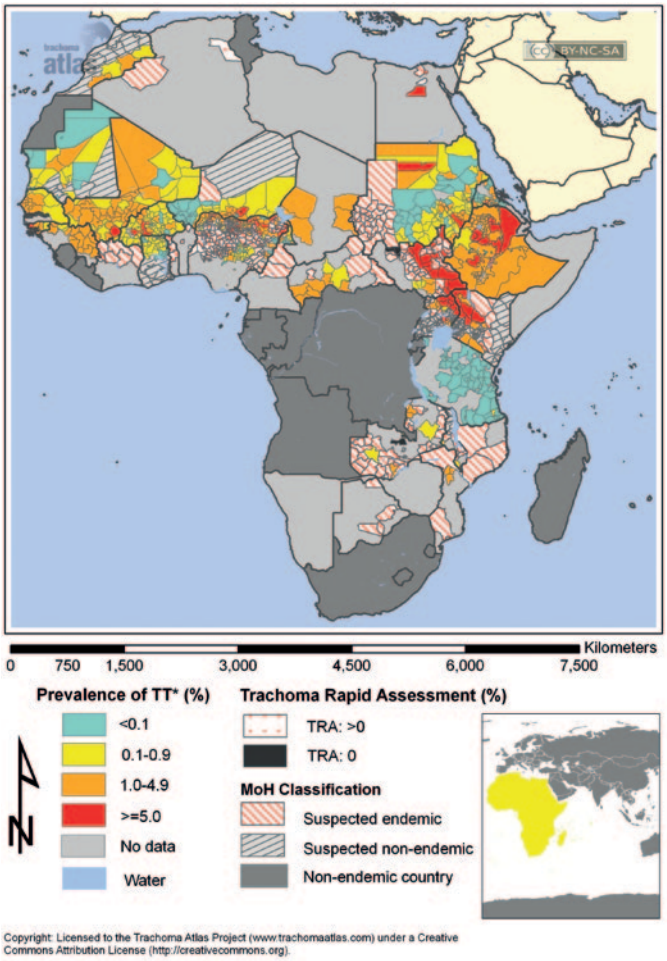
Map 1: Map of Africa showing the countries to be supported by the FTI for the elimination of blinding trachoma



Map 2: Map showing prevalence of active trachoma in Africa

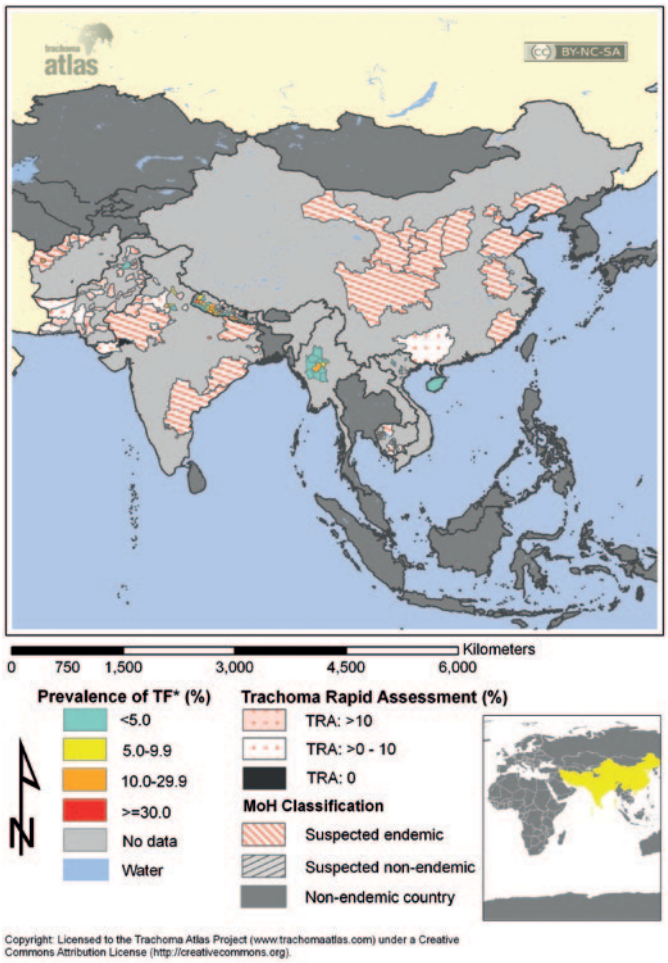


Map 3: Map showing prevalence of trichiasis in Africa



Map 4: Prevalence of trachoma in Asia and Western Pacific

Active Trachoma



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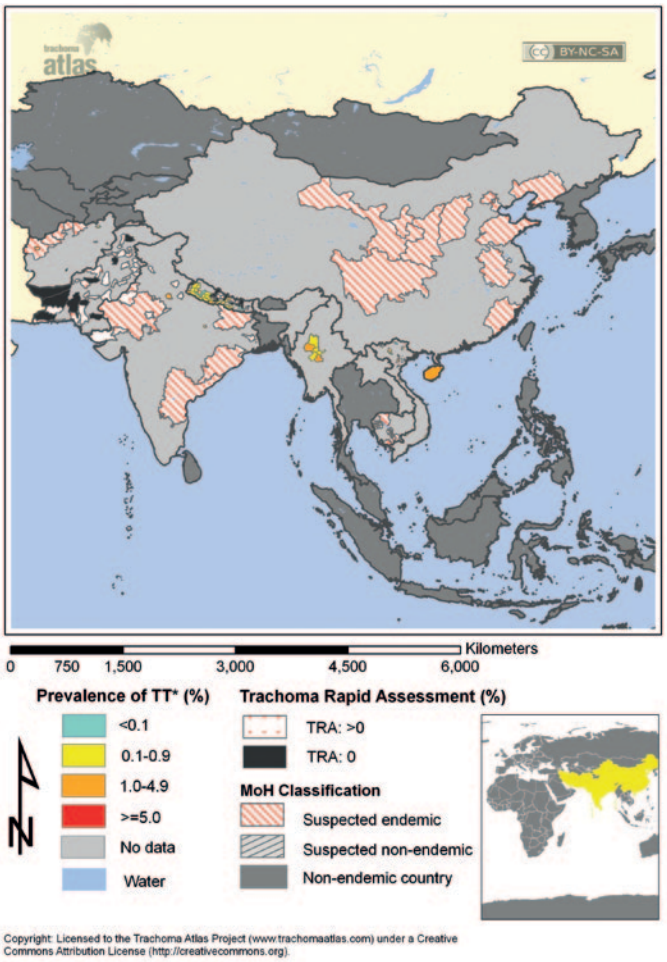
Trichiasis



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The countries in which we intend to fast-track the elimination of blinding trachoma and some of their data is in Tables 1, 2 and 3 below. Overall, the total population for these countries is estimated to be about 1.8billion in 2010. It is estimated that about 700 endemic districts in these countries will benefit from this initiative. 350 districts are already confirmed endemic; 753 districts are suspected to be endemic for trachoma. It is expected that 50% of the suspected endemic districts will actually be found to be endemic when baseline surveys are conducted. This is based on the trend seen so far in the baseline surveys already conducted.

Thus, 377 districts are likely to be confirmed endemic. The total number of endemic districts that will need intervention in our target countries will therefore be 725– approximately 700 districts. In Africa, most districts have a population of 120,000 to 250,000 people with an average of 200,000. We have used the lower limit of 120,000 people per district to calculate the need for antibiotics considering that there may be districts that would only need to treat some sub-districts and communities and not the entire district. Hence a total of about 84million people will benefit directly from this initiative and about 1.8 billion will benefit indirectly.

Table 1: Countries with total population & population at risk for trachoma

	Country	Total country population	Population at risk		
			Confirmed endemic	Suspected endemic	Total confirmed & suspected endemic
1	Benin	9,800,000		188,037	188,037
2	Burkina Faso	16,200,000	7,205,383		7,205,383
3	Cameroon	20,000,000	1,744,698	2,450,813	4,195,511
4	CAR	4,900,000		238,998	238,998
5	Chad	11,500,000		4,914,030	4,914,030
6	Ghana	24,000,000		0	0
7	Guinea	10,800,000	3,745,300		3,745,300
8	Guinea Bissau	1,700,000	191,338	1,339,170	1,530,508
9	Kenya	40,100,000	2,239,677	3,229,515	5,469,192
10	Malawi	15,500,000	1,311,420	1,861,174	3,172,594
11	Mali	15,200,000	1,179,501		1,179,501
12	Mozambique	23,400,000	151,788	13,103,767	13,255,555
13	Niger	15,900,000	9,274,849		9,274,849
14	Nigeria	158,300,000	18,091,360	43,383,782	61,475,142
15	Senegal	12,500,000	2,589,103	7,412,734	10,001,837
16	South Sudan	8,260,490	2,933,718	2,560,867	5,494,585
17	Sudan	30,894,000	546,240	10,458,198	11,004,438
18	Tanzania	45,000,000	9,906,874		9,906,874
19	The Gambia	1,800,000	120,695		120,695
20	Togo	6,800,000			0
21	Uganda	33,800,000	8,283,225	1,966,671	10,249,896
22	Zambia	13,300,000	2,162,140	6,152,568	8,314,708
	Sub-total	519,654,490	71,677,309	99,260,324	170,937,633
23	India	1,188,800,000	12,565,900	412,626,832	425,192,732
24	Pakistan	184,800,000		38,003,995	38,003,995
	Sub-total	1,373,600,000	12,565,900	450,630,827	463,196,727
	Total	1,893,254,490	84,243,209	549,891,151	634,134,360

Table 2: Countries- Total number of districts and number of endemic districts

	Country	Total number of Districts in the Country	Number Confirmed Endemic Districts	Number Suspected Endemic Districts	50% of Suspected Endemic Districts	Number of confirmed + 50% of suspected endemic districts	Total number Confirmed + suspected endemic
1	Benin	77					
2	Burkina Faso	63	30			30	30
3	Cameroon	178	13	23	12	25	36
4	CAR	51		21	11	11	21
5	Chad	14		8	4	4	37
6	Ghana	170	29	8	4	33	8
7	Guinea	38	15			15	15
8	Guinea Bissau	N/A	20	38	19	39	58
9	Kenya	80	5	10	5	10	15
10	Malawi	27	2	8	4	6	10
11	Mali	61	10			10	10
12	Mozambique	131	3	72	36	39	75
13	Niger	42	23			23	23
14	Nigeria	774	79	209	105	184	288
15	Senegal	34	13	12	6	19	25
16	South Sudan	80	26	28	14	40	54
17	Sudan	133	3	37	19	22	40
18	Tanzania	121	43			43	43
19	The Gambia	41	7			7	7
20	Togo	30					
21	Uganda	112	25	0	0	25	25
22	Zambia	72	5	36	18	23	41
	Sub-total	2,329	351	510	257	608	861
23	India	565	2	198	99	101	200
24	Pakistan	133		31	16	16	31
	Sub-total	698	2	229	115	117	231
	Total	3,027	353	739	372	725	1092

Table 3: Situational Analysis of countries for SAFE

	Country	Current % TF Range	Current % TT Range	Water Coverage	Household latrine coverage	Year of Survey
1	Benin	42.0	No data	60-79 (68)	12-58(32)	2005
2	Burkina Faso	1.4-21.1	0.0-2.2	44-82 (51)	5-45 (12)	2005
3	Cameroon	0.5-42.5 (12.5)	0-7.3(1.08)	41-84(63)	33-63(48)	2006-2010
4	CAR	6.6	0.6	51-92(67)	28-43(34)	2008
5	Chad	?	?	32-40(34)	0-30(8)	2001-2005
6	Ghana	0.14-2.8	0-1.07	64-88(75)	11-27(18)	2007-2008
7	Guinea	20-40	0.9-4.7	70	34	2001-2002
8	Guinea Bissau	18.3	2	49-79(59)	23-57(34)	2004-2010
9	Kenya	6.4-67.6	1.0-13.3	46-89(62)	43-56(48)	2004-2010
10	Malawi	13.6-21.7	0.3-0.6	62-96(67)	42-66(46)	2002-2003;2008
11	Mali	0.3-66.6	0.1-2.6	35-76(60)	39-59(45)	2009
12	Mozambique	40	4.0	24-76(42)	14-51(27)	2002
13	Niger	3.9-49 (36.4)	1.7	32-91(42)	3-27(7)	2001-2006
14	Nigeria	5.1-49 (24.7)	0.2-5.9(4.7)	49-72(60)	30-48(38)	2002;2005-2006
15	Senegal	3.3-17.9 (7.5)	2.0	54-90(72)	34-70(52)	2002-2004
16	South Sudan	33.2-80.1	1.3-19.2	64-78(69)	24-50(34)	2001-2005
17	Sudan	0-19.8	0.19-6.65	69.4	46	2006-2009
18	Tanzania	3.7-64.7	0.2-12.5	17-64	83-95	1999-2006
19	The Gambia	0.0-3.6	0-0.25	81-95(98)	23	2007-2009
20	Togo	11.0	No data	40-86(59)	3-24(12)	
21	Uganda	6.9-65.7	2.1-17.8	52-87(68)	39-53(41)	2006-2009
22	Zambia	9.7-32.1	0.1-1.5	36-90(56)	39-53(41)	2007-2008
23	India	0.9-15.2 (6.0)	0.04-0.27	84-96(88)	21-54(31)	2006
24	Pakistan	0-15.4	>1	87-95(90)	35-92(54)	2010-2011

It is noteworthy that some of these countries have begun to have an upward economic growth. However, they are still in their early or middle developmental stages and a number of them are in post war era and need a great technical and financial support to enable them carry out the full SAFE Strategy.

A cursory look at the overall burden of disease shows that close to 50% of the people who need surgery to correct their in-turned lashes in the world live in the Sightsavers supported countries in Africa and Asia; about 70 percent of them are women. A total of about 1.8 billion people in these countries are at risk of trachoma and about 84 million people will be in need of antibiotic treatment. About one million people will be provided with lid surgery to prevent blindness.

The current plan for trachoma in the fast track countries includes the key issues of the SAFE strategy. The Sightsavers fast-track initiative for elimination of blinding trachoma is committed to a comprehensive strategic plan with an ultimate goal of eliminating blinding trachoma by 2020 to meet the global target. This more detailed strategic plan seeks to demonstrate the full implementation of the SAFE strategy and work with partners to scale up the expansion of trachoma control to all endemic districts in the Sightsavers supported countries. The programme will carry out baseline prevalence surveys to assess carefully the backlog of trichiasis cases and to estimate the Azithromycin requirement for the next 10 years and provide support for the implementation of the SAFE strategy. Countries which are endemic for trachoma but do not yet have strategic plans for control and elimination will be assisted to develop and implement their plans. The programme will also assist countries which have reached their ultimate intervention goals (UIGs) to establish a surveillance system and work towards certification.

Azithromycin is provided free from Pfizer Inc. through ITI to all community members who need antibiotic treatment for trachoma. A plan for annual requirements of the antibiotic is needed in order to guarantee a smooth and timely supply. Countries will be assisted to make yearly forecasts for their antibiotic needs in their annual implementation plans.

1.2 Framework for trachoma strategic plan

Sightsavers in her new strategic direction is working in accordance with global initiatives and seeks to fit into the overall 6 building blocks and the 4 attributes of the Health Systems Framework to produce the 4 outcomes; the WHO call for the Global Elimination of Trachoma by 2020- GET-2020 and the Millennium Development Goals. The Sightsavers Fast Track Initiative for Trachoma is based on the Primary Health Care (PHC) strategy and guided by principles of piloting, demonstrating and scaling up using decentralized and integrated service delivery and management. However, it is also worth mentioning that for an elimination programme there would be the need for some vertical programme implementation such as training of TT surgeons and actual provision of surgery to people with TT. Implementation of some advocacy activities may be by both horizontal and vertical means.

1.3 Health Systems Strengthening

The health systems framework is made up of 6 building blocks:

1. Health Work Force.
2. Infrastructure and Technology.
3. Financing.
4. Health Information, Surveillance and Research.
5. Service Delivery.
6. Leadership and governance.

Four attributes:

1. Access.
2. Coverage.
3. Quality.
4. Safety.

Four outcomes or goals:

1. Improving efficiency.
2. Improving Health.
3. Responsiveness.
4. Social and financial risk protection.

Advocacy, research and evidence are key areas that will be addressed in this programme.

Table 4: Health Systems Strengthening by the Programme

Surgery	Antibiotics	Facial Cleanliness	Environmental Improvement
Human Resource:			
Capacity strengthened for case detection & trichiasis surgery; (looking at quality of surgery) , surveillance (prevalence of disease).	Capacity building in drug logistics management system; capacity building in conducting epidemiological surveys as a basis for intervention (treatment with antibiotics).	Capacity building for advocacy & communications skills; improvement in C4D (communication for development).	Capacity building for advocacy for provision of water and sanitation for all members in the endemic communities including people with disability.
Infrastructure and Technology:			
TT surgical kits provided; integration into and strengthening of procurement and distribution systems; improvement existing facilities for surgery.	Medical stores expanded and/or refurbished; Availability of standard guidelines for supply and storage and distribution system that minimises leakage and wastage.	Water facilities provided in schools and communities.	Knowledge of appropriate technology methods for latrine construction and environmental sanitation transferred to community members.
Financing:			
Capacity building in the management of donor funds; country programmes supported to generate/ raise funds internally. Capacity building of communities to conduct advocacy and raise funds internally. Financial risk protection is incorporated in this programme to ensure all who need treatment for trachoma are well covered.			
Health Information, Surveillance and Research:			
Integration into HMIS and strengthening of HMIS; capacity building in the conduction of epidemiological surveys with due recognition of vertical interventions; Training of personnel in the use of generated data and information. Provision of technology such as computers and mobile phones.			

Surgery	Antibiotics	Facial Cleanliness	Environmental Improvement
Service Delivery:			
Provision of adequate logistics, vehicles, surgical consumables, etc, which can be used for other NTDs and other health intervention needs; Provision of community-based surgery to clients with trichiasis.	Joint activities with the distribution of ITNs will be cost efficient; Availability and accessibility of drugs-Azithromycin and Tetracycline eye ointment to community members using the community directed treatment through door to door delivery of antibiotics.	Assisting the health sector to form alliances with agencies especially NGOs and community development agencies in the Water and Sanitation Sector; Assisting the health sector to hand over the water and sanitation aspects of the interventions to the relevant sector ministries; Linking these social determinants with current global initiatives.	
Leadership and Governance:			
Development of taskforce at all levels will help to improve overall collaboration between government and other partners in districts and countries. Availability of up-to-date national trachoma or NTD strategy plans and budget linked to national needs and priorities; Availability of Annual Reports; Availability of survey reports will aid in planning, implementation and evaluation of country programmes; Availability of treatment standards and protocol; Systems put in place to ensure accountability to communities through all phases of the programme.			
Innovations:			
Operational Research: There will be links of research to demonstration models; Monitoring and Evaluation and Research will work together to ensure models are robust and effective before getting others to take the programme up. Inclusive promotional material. Greater engagement with non state actors such as family and communities in health education and promotion to ensure continuous quality care to members of endemic communities. Increased ownership and participation of communities in all interventions. Social Inclusion and rights-based ideals incorporated into the provision of water and sanitation facilities.			
Quality Assurance:			
Compliance with minimum international standards of quality. Quality Assurance staff to actively participate in the programme. Peer review of country programmes will lead to increasing quality attainment.			

This programme will ensure that these building blocks are used for an excellent and sustainable programme development, implementation, monitoring and evaluation. The fast track initiative for the elimination of trachoma programme will demonstrate improvement in efficiency by integrating most activities into the Primary Health Care system, co-implementing some activities with other programmes such as the Neglected Tropical Diseases Control Programme, Malaria Control Programme, etc. Our overall aim is to improve the health of community members and letting them have a better life by preventing people from going blind from trachoma by providing them with the cost effective (bilamellar tarsal rotation procedure (BTRP) surgery.
By advocating for the provision of water and household latrines and forming strategic

partnerships with organizations in the water and sanitation sector, we would be improving the social determinants of health of the communities. Antibiotics and surgery will be provided free of charge to members of endemic communities.

Vision 2020 "The Right to Sight" is a global declaration launched by The World Health Organization (WHO) and international partners. Various Ministries of Health (MOH) have endorsed the Vision 2020 "The Right to Sight" initiative. Sightsavers is a key partner and advocate for the implementation of Vision 2020 "The Right to Sight". Trachoma is one of the diseases which are addressed by Vision 2020.

The Alliance for the Global Elimination of Blinding Trachoma, GET 2020

The Alliance for the Global Elimination of Blinding Trachoma by the year 2020 (GET 2020) was launched under WHO's leadership in 1997. The Alliance, led by WHO, is a partnership formed to support country implementation of the SAFE strategy. The members of the Alliance include WHO, national governments, nongovernmental organizations, research institutions, foundations and the pharmaceutical industry. Sightsavers, a member of this alliance, will work very closely with the Alliance and its leadership- the Prevention of Blindness and Deafness Unit, WHO, Geneva, drawing on its rich experiences on trachoma control as well as for its links with the Neglected Tropical Diseases Control Programme. The leadership of the alliance will provide technical support in the provision of guidelines, be involved in advocacy issues as needed and have a monitoring role in this initiative.

Trachoma and the Neglected Tropical Diseases Control Programme

Trachoma is one of the Neglected Tropical Diseases (NTDs) using mass drug administration (MDA) as part of its key strategy for control of the disease. The fast track initiative will work very closely and together with the global teams working on the control and elimination of NTDs from the globe. Sightsavers will continue to be part of the global network working on integrating the NTDs programmes for a more cost efficient programme implementation.

Trachoma and Malaria Control Programme

Malaria, Tuberculosis and HIV/AIDS are the three big killer diseases. Programmes targeting these diseases are most often well developed and resourced. The neglected tropical diseases, of which trachoma is one, are usually not so resourced financially. The subject of integrating trachoma and malaria control activities has been discussed at various forums as both require community-based interventions. Unfortunately, there are only a few examples of such integration. The fast track initiative will seek to find areas in which innovative community-based interventions of the two diseases could be integrated. A successful implementation of such joint activities will be of value to both programmes and more so to the people who are being helped to have improved lives. The programme will conduct research activities in this area, pilot worthwhile projects and market them for up-scaling.

Trachoma and Social Determinants of Health

Trachoma is a disease that affects the poorest of the poor. It is found in dry, dusty and dirty environments. Most trachoma endemic communities do not have access to safe water and sanitation facilities. It is found more often in poor rural areas with low literacy rates. Health care facilities are usually not easily accessible to such communities. The fast track initiative for the elimination of blinding trachoma will make advocacy for the general improvement of the social determinants of health in the trachoma endemic areas.

Trachoma and the Millennium Development Goals (MDGs)

Implementing the full SAFE strategy contributes to the achievement of all the Millennium Development Goals (MDGs). Provision of surgery to people with TT prevents blindness and contributes to poverty reduction (MDG1). The treatment of communities, including children,

with antibiotics as well as the hygiene promotion on facial cleanliness, helps children to have clean faces without eye discharges and itching and therefore they are healthier and can attend school regularly contributing to MDG2. Provision of sanitation facilities in schools promotes girl attendance (MDG3). Provision of safe water reduces incidence of diarrhoeal diseases thereby contributing to the reduction of infant and child mortality (MDG4, 5, 6) Trachoma control activities include the provision of water and household sanitation facilities thereby contributing to MDG7. The SAFE strategy implementation promotes partnership between governmental, non governmental organisations and private sector companies contributing to (MDG8).

1.4 Process for the Strategic Plan

The strategic planning process for the Fast Track Initiative for Trachoma started with a situational analysis of the countries. The situational analysis report was compiled in March-May 2010 and again in August- September 2011 for updates. The situational analysis reports from the countries were used as background materials. One-on-one discussions were also made with both Sightsavers Country Directors as well as representatives from some Ministries of Health. Information from country Ministries of Health and other partners were channelled through the Sightsavers Country Directors and other key persons. Inputs were also made by other colleagues in Sightsavers and other partners. The 2020 INSight document was also used to get some data and information. The 2011 reports submitted by countries to WHO for the GET 2020 meeting were also used.

Recommendations from various WHO GET 2020 meetings, results of various research work done by trachoma experts as well as lessons learnt and best practices from other country programmes were all considered in the formulation of this strategic plan. Reports on the MDGs relating to water and sanitation coverage were carefully looked at and much information was gathered from these sources especially those from the UNICEF reports.[8] Best practices and lessons learnt from the Neglected Tropical Diseases Control Programme especially those from the Onchocerciasis Control Programme (OCP)- Sightsavers has acquired much experience over her 60 years of supporting countries in their OCPs- also served as basis for our strategic plan.

A SWOT analysis was carried out on trachoma control in the Sightsavers supported- countries by the programme teams. Based on the results of the situational analysis and the SWOT analysis, objectives, outputs and activities were modified using a logical framework approach to develop a strategic plan for 2011-2020. In the listing of activities for the objectives of SAFE strategy it was carefully considered that the activities were relevant, have a measurable impact and would lead to sustainable development.

It is expected that the overall coordination and leadership at the country level will be done by the various governments especially the Ministries of Health. Sightsavers will support the governments by facilitating the implementation of activities.

2.0 Strategic Plan for Fast Track Elimination of Blinding Trachoma

2.1 Vision

24 countries; 22 in Africa and 2 in Asia, India and Pakistan free from blinding trachoma.

2.2 Goal

To fast track the elimination of blinding trachoma from the 24 Sightsavers supported countries (2 of these countries, CAR and Chad, through partnership with OPC) by 2020.

This means that:

The prevalence of active trachoma TF is less than 5 percent among children aged 1 to 9 years old and prevalence of trachoma trichiasis is less than 1 case per 1000 population.

2.3 Strategic Fit for Fast Track Initiative for Trachoma Blindness Elimination into the overall Sightsavers new Strategic Direction

1. To support governments to ensure that quality eye care is universally available as an integral part of wider health systems.
    a. To demonstrate scalable cost effective approaches to eye health which also strengthen health systems- to improve efficiency of the country programmes, increase programme coverage in endemic districts and countries, and to provide quality care in base health facilities and on outreach services.
    b. To develop effective partnerships- that is to foster closer collaboration and partnership between the public sector and communities, other sectors, non-governmental organizations, private health providers and other interested groups.
    c. To develop country level teams to plan, implement, monitor and evaluate their programmes.
    d. To fund our work through growth and diversification of income- to increase the overall resources and ensure equitable and efficient distribution of resources in endemic districts and countries.
2. To conduct a community participatory health education and hygiene promotion with members of communities so they would seek eye health services and enjoy a change in quality of life through community development programmes:
    a. To ensure that our programmes are rooted in community development.
    b. To establish strong networks and alliances.
    c. To establish effective information sharing systems.
    d. To use resources strategically and efficiently.

2.4 SAFE strategy

The SAFE strategy is a WHO recommended strategy for elimination of blinding trachoma by 2020. The components for the SAFE strategy are:

- **S** = **S**urgery for trichiasis.
- **A** = **A**ntibiotics for active disease.
- **F** = **F**acial cleanliness to reduce transmission.
- **E** = **E**nvironmental improvement to reduce transmission of Chlamydia trachomatis.

2.5 Outcome Objectives

For the moving from active elimination of blinding trachoma to surveillance of the disease, WHO has set 2 main criteria:

1. TF should be less than 5 percent in 1 to 9 year old children at the community level.
2. TT should be less than 1 case per 1000 population in over 15 year-old population.

2.6 Output Objectives

1. To provide surgery to at least one-third (i.e one million) of current backlog of TT patients in our target countries by 2020.
2. To maintain TT recurrence below 10 percent.
3. To expand antibiotic distribution to cover all endemic districts (700) in the 24 countries (about 84 million people to benefit).
4. To have at least 80 percent of children 1 to 9 years old with clean faces in the endemic communities.
5. To intensify advocacy toward increased access to water by about 20% and sanitation by about 30% in all endemic communities in the target countries as a human rights issue.
6. To conduct both basic and operational research to enhance learning and provide evidence for elimination.

3.0 Strategic Plan according to the SAFE components

The results of the SWOT analysis are transformed into objectives, outputs and activities of the SAFE strategy. The expected outputs for the objectives are described as well as the activities to achieve the outputs. Risks and assumptions are analysed. The plan is put into a logical framework approach table at the end of this document. This table includes the indicators for the activities, the source of verification and the time frame.

3.1. Gathering of Data

Ultimate Intervention Goal:

All 24 countries to have current population based survey data (baseline, impact and surveillance survey data) which will guide programme implementation towards reaching the UIGs, conduct surveillance activities where the UIGs have been met and work towards certification of the elimination of blinding trachoma by 2020.

Objectives:

1. To provide support to countries to conduct baseline surveys in the 739 trachoma suspected endemic districts in the 24 target countries by 2014.
2. To provide support to countries to conduct impact surveys in 725 programme districts in the 24 target countries from 2012 to 2017.
3. To provide support to countries to carry out surveillance surveys in 727 programme districts in the 24 target countries from 2012 to 2017.

Outputs:

1. Baseline prevalence surveys in 739 districts carried out.
2. Impact surveys carried out in 725 districts after 3-5 years of SAFE implementation.
3. Surveillance surveys carried out in 725 districts on reaching their UIGs yearly for 3 years.

Activities:

Countries will be assisted to conduct population based surveys appropriate for the needs of the country. District level data will be collected where needed and where regional level baseline surveys will be more cost effective based on the suspected prevalence rates that level of survey will be conducted. The WHO guidelines will be adapted and used. Countries will be encouraged to use other proven methods which are cost effective. Integrated surveys with other NTDs will be encouraged where feasible and appropriate. Innovative approaches will also be encouraged to enhance learning and improving ways of getting data in the most cost effective way.

3.2 Country Strategic Plan Documents

Ultimate Intervention Goal:

All 24 countries to have a national multi-year strategic plan document for the elimination of blinding trachoma by 2013.

Objectives:

1. To provide support to countries without a strategic plan for trachoma to develop a multi-year strategic plan document for the elimination of blinding trachoma by 2013.
2. To provide support to countries with multi-year strategic plans to conduct a midterm or end of term evaluation of their country plans and review their plans.

Outputs:

1. Countries have national multi-year strategic plan for the elimination of blinding trachoma.
2. Countries with strategic plans in place have their plans evaluated and necessary changes effected.

Activities:

It is very important for each trachoma endemic country to have a multi-year strategic plan document for the elimination of trachoma. This document may be a single disease document by itself or be part of the wider eye health Vision 2020 Plan or part of the Integrated Neglected Tropical Diseases Control Programme.

Countries without national plans will be provided with the needed assistance to enable them to develop plans. The Trachoma Action Plan template developed as part of the ICTC INSight 2020 document and accepted by the GET 2020 Alliance will be used. These plans will be aligned to the NTD Master Plan being developed by WHO. This will be done in a collaborative effort between the Ministries of Health, Sightsavers and all stakeholders for ownership.

Countries with plans already in place will be assisted to conduct a midterm evaluation of their plans when due and make the necessary improvements to enable them reach their desired goals. The evaluation will be conducted in a participatory manner consisting of both external evaluators and programme managers and other stakeholders.

Table 5: Countries and strategic plan documents

	Country/Year	Availability of National Strategic Plan for Trachoma or NTD	Period of Plan	Need for immediate Mid-term Review	Need for immediate End of term Review	Need for a new National Plan	Expected Year of elimination
1	Benin	✓	2010-2015	✗	✗	✗	2020
2	Burkina Faso	✓	2007-2009	✗	✓	✓	2020
3	Cameroon	✗	N/A	N/A	N/A	✓	2020
4	CAR	✗	N/A	N/A	N/A	✓	2015
5	Chad	✗	N/A	N/A	N/A	✓	2020
6	Ghana	✓	2005-2009	✗	✓	✗	2010
7	Guinea	✗	2010-2015	N/A	N/A	✓	2020
8	Guinea Bissau	✓	2008-2010	✗	✓	✓	2019
9	Kenya	✓	2008-2015	✓	✗	✗	2015/2020
10	Malawi	✗	N/A	N/A	N/A	✓	2020
11	Mali	✓	2005-2009	N/A	✓	✓	2015
12	Mozambique	✗		N/A	N/A	✓	2020
13	Niger	✓	2005-2009	N/A	✓	✓	2015
14	Nigeria	✓	2008-2010 2010-2014	✗	✗	✗	2020
15	Senegal	✓	2006-2010	✗	✓	✓	2020
16	South Sudan	✗		✗	✗	✓	2020
17	Sudan	✓	2011-2015	✗	✗	✗	2015
18	Tanzania	✓	2004-2008 2009-2014	N/A	✗	✗	2020
19	The Gambia	✓	2007-2009	✗	✓	✗	2011
20	Togo	✓	2010-2012	N/A	✗	✗	2020
21	Uganda	✓	2011-2015	N/A	✗	✗	2020
22	Zambia	✓	2011-2013	N/A	N/A	✗	2020
23	India	✗	N/A	N/A	N/A	✓ to be done	2020
24	Pakistan	✓	Until 2015	Already done	A survey underway	Depends on results of new surveys	2015

Table 6: Programme coverage and exit in Countries by 2020

Country/Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Benin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Burkina Faso	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cameroon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CAR	✓	✓	✓	✓	✓	✓	✓			
Chad	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ghana	✓	✓	✓	✓						
Guinea	✓	✓	✓	✓	✓	✓	✓	✓		
Guinea Bissau	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kenya	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Malawi	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mali	✓	✓	✓	✓	✓	✓	✓	✓		
Mozambique	✓	✓	✓	✓	✓	✓	✓	✓		
Niger	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Nigeria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Senegal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Sudan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sudan	✓	✓	✓	✓	✓	✓	✓			
Tanzania	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
The Gambia	✓	✓	✓	✓						
Togo	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Uganda	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Zambia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
India	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pakistan	✓	✓	✓	✓	✓	✓	✓			

Risk and assumption:

Some countries do not have a complete mapping of the trachoma endemic districts. It is also not yet fully known what the TF and TT prevalence rates are for all endemic districts in the countries. An assumption that 50% of the suspected trachoma endemic districts will be confirmed as such has been made; this is based on the trend of previous survey data. The number of total confirmed endemic districts may therefore be more or less than the 700 districts provided for in this document. Unforeseen situations such as wars and natural disasters may prevent programmes from making progress as planned before.

3.3 Component S: Surgery

Ultimate Intervention Goal: Operate on one million TT patients.

Objectives:

1. To clear about one-third of the backlog of TT surgeries in the 24 Sightsavers supported trachoma endemic countries by 2020.
2. To maintain TT recurrence rate below 10 percent.

Outputs:

1. One million TT cases are operated by 2020.
2. Recurrence is below 10 percent per surgeon.

Activities:

Health workers and volunteers such as teachers, environmental health officers, traditional birth attendants, and village health volunteers will be trained/re-trained yearly by ophthalmic nurses for case detection. A total of 14,000 health workers (20 per district) and 140,000 (200 per district) volunteers will be trained for the countries per year within the 10 year period. Keynotes of people centeredness approach will be incorporated into the training for health workers and volunteers.

Systematic active TT case search will be carried out in all communities in the endemic districts by the trained health workers and volunteers. Awareness for surgery will be created using the mass media, print materials and community durbars. This could lead to self detection of trichiasis and individuals making personal efforts to access surgery. Raising the acceptability of surgery will be done by intensified health education sessions on one-on-one basis by trained counsellors and the use of satisfied clients' testimonies. The integrated IE&C materials produced by Sightsavers with funding support by USAID/World Vision in Ghana could be adapted and used by countries.

A service delivery manual for surgical services will be developed and adapted for the countries. Equipment like surgical kits, sterilizers and consumables will be purchased for surgery. There is the need to have at least 1800 trained TT surgeons for the programme. The number of TT surgeons to be trained per country will be determined by the backlog of TT cases, the number of already trained TT surgeons and their performance. For ease of planning it is assumed that about 2 TT surgeons may need to be trained per district for the 700 districts.

Currently there are about 16,000 trained and available trichiasis surgeons in the trachoma endemic countries in the targeted 24 countries. 957 of these are available in the 22 supported countries in African. 15,800 of them are in India (14,000) and Pakistan (1,800). Training for an additional 1,000 new surgeons will be needed- almost all of them needed for the countries in Africa. Refresher training will also be conducted for the already trained TT surgeons where necessary. It is expected that 300 new TT surgeons will be trained in 2011. An additional 400 new TT surgeons will be trained each year for the following two years. Refresher training will be conducted each year after that as needed by country programmes.

In view of the possibility that some surgeons may be transferred to non-programme areas or leave the trachoma programme for other appointments, 200 TT surgeons will be trained/ retrained each year in order to supplement the number of people able to perform the surgeries. The surgeons will be certified after the training using the WHO guidelines. Ophthalmologists and cataract surgeons who would be interested and dedicated to the task of training and supervising trained TT surgeons will be identified and supported to carry out these tasks. The training will be carried out by the Ophthalmologists in the programme countries and will be community based as it is also a means of removing barrier and increasing surgical output. The duration of each initial training session will be 10 days while the refresher training will last 5 days. The WHO manual, "Trichiasis surgery for trachoma: the

Bilamellar Tarsal Rotation Procedure" will be used as guidelines for training. The WHO manual for the certification for Trichiasis Surgery Using the Bilamellar Tarsal Rotation Procedure[9] will be used for certification. Country programmes should establish a minimum number of operations performed by the trainees before sending them for certification.

The backlog of surgeries is estimated to be about three million cases in the target countries- (see table 8 below). Sightsavers will however contribute towards the provision of surgery to one million, one–third of the people with trichiasis in our target countries. Targets per year are as shown in Table 7 below. In 2009, a total of about 12,886 TT cases were operated by Sightsavers and partners. It is expected that governments, other agencies and NGOs will provide support to clear the rest of the backlog.

Table 7: Plan for clearing of backlog of TT surgeries by 2020 (based on INSight 2020 suggested scenario for surgery scale up)

Year	Surgeries planned
2011	30,000
2012	45,000
2013	75,000
2014	75,000
2015	105,000
2016	120,000
2017	120,000
2018	120,000
2019	145,000
2020	165,000
TOTAL	1,000,000

Table 8: Situational analysis of countries- Surgery

	Country	TT Prev. rate	Current TT Backlog	Total number of confirmed and 50% of suspected endemic districts	Number of TT Surgeons Available	Number of additional TT Surgeons to be trained
1	Benin	No data			?	?
2	Burkina Faso	0.0-1.55	30,303	30	81	0
3	Cameroon	0-7.3 (1.09)	47,200	25	8	64
4	CAR	0.6	24,915	11	10	32
5	Chad	?	34,300	4	?	16
6	Ghana	0-1.7	1,000	33	23	10
7	Guinea	0.9-4.7 (2.7)	25,528	15	10	20
8	Guinea Bissau	0.2-12 (3)	7,361	39	13	45
9	Kenya	1.0-13.3	114,000	10	52	60
10	Malawi	0.3-0.6	33,400	6	10	10
11	Mali	0.04-2.42 (2.51)	40,705	10	61	0
12	Mozambique	4.0	60,500	39	?	75
13	Niger	0-7.03 (1.7)	35,763	23	167	0
14	Nigeria	0.2-5.9 (4.7)	1,291,001	184	50	238
15	Senegal	1.4-4.7 (2.0)	91,500	19	38	12
16	South Sudan	1.3-19.2 (12)	96,364	40	33	125
17	Sudan	0.4-6.65 (1.0)	31,072	22	120	0
18	Tanzania	0.2-12.5 (2.7)	130,000	43	200	0
19	The Gambia	0-0.25	0	7	28	0
20	Togo	No data	2,900		?	10
21	Uganda	0.9-17.8	167,538	25	51	102
22	Zambia	0.1-1.5 (0.7)	270,800	23	2	121
	Subtotal		2,536,150	610	957	940
23	India	0.03-1.97	443,000	101	14,000	0
24	Pakistan	< 1%	71,700	16	1800	0
	Subtotal		514,700	117	15,800	0
	Total		3,050,850	727	16,757	940

A total of about 1800 TT surgeons (about 900 already trained and an additional 900 needed to be trained mainly in Africa) will be needed to clear the backlog of trichiasis cases in Africa. From the situational analysis, India and Pakistan have more than enough trained and available TT surgeons. They will therefore not require new TT surgeons to be trained but some of the TT surgeons may need refresher training. The actual number of TT surgeons to be trained will be based on the backlog of TTs in a particular district or country. Hence the number trained will differ from district to district and from country to country and it will be proportional to the backlog. The present number of operating TT surgeons is about 16,000 in the 24 endemic countries; 950 in Africa and over 15,000 in Asia. An estimated 1000 more TT surgeons will need to be trained over the next three years. Retraining of 200 TT surgeons will be conducted yearly for the subsequent years. By this arrangement each endemic district will have at least 2 TT surgeons dedicated to the clearing of the TT backlog in the districts. The fast track initiative will aim at providing TT surgical kits for 3,600 TT surgeons: 1,800 for countries in Africa and another 1,800 for countries in Asia. Ideally, each surgeon will need to have 3 TT surgical kits. The fast track initiative will contribute 2 TT surgical kits per surgeon. Additional kits will be purchased to replace worn-out ones. Training on the use, care and maintenance of the TT sets will be integrated into the main training of the TT surgeons. It is estimated that 7,200 kits would be purchased during the first phase of three years. The second set of 7,200 kits will be purchased to replace the first ones after 5 years of use.

It is worth noting that each surgeon may work for a total period of six to eight months in a year considering the other tasks they have to fulfil as well as their annual vacation and periods of inaccessibility to communities. It is expected that each trained surgeon will perform about 120-200 TT surgeries per year to enable them maintain and improve on their skill. It is important to retain talented and hardworking TT surgeons. Sightsavers will work with the leadership and management of country programmes to find and adopt innovative ways of retaining such personnel to avoid losing them. The approach may differ from country to country depending on their work and remuneration culture.

Surgeries will be carried out mainly at the community level using the outreach and eye camp strategy. Timing for outreach and eye camps will be planned by the district programme managers in conjunction with the community leaders and the TT surgeons to ensure that activities are carried out when it is most convenient for the communities. Eye camps would however need to be carried out in the dry seasons when most communities are accessible.

Although surgeries will be carried out mainly at camps and during other outreach programmes, facility based surgeries will also be provided to people with trichiasis who walk into the eye care facilities.

For guaranteeing the quality of the surgery, the recurrence rate should be kept under 10 percent per surgeon. Every surgeon would keep a TT register. The Programme will develop quality assurance protocol for follow-up and monitoring of operated cases. Post-operative follow-up will be done on the 2nd and 8th day. A third visit will be conducted at the end of the 6th month. The surgeries will be monitored and periodic surgical audits performed by TT surgeons as well as the supervising Ophthalmologist. The Programme will carry out surveys for TT recurrences once every 2 years.

For people with only 1 or 2 lashes at the corners of their eyelids without touching the cornea, epilation of the offending lashes could be done for them and follow up done to ensure that they receive surgery when the need arises.

For people with TT who refuse surgery, the programme will give them two more opportunities to receive surgery after they have been counselled again. If they refuse on the third occasion, their names will be cancelled from the backlog.

Risks and assumptions

The number of operations will depend on IEC campaigns in the communities and training of health staff and volunteers to find the TT cases. The second risk is the acceptance of surgery which also needs health education and also depends on good results of the performed surgery as well as issues of people centeredness ideals. If the recurrences and complications are high, clients will not accept the surgery. If clients are not treated with respect they may refuse to have surgery.

Provision of surgery is dependent on continuous availability of surgical consumables. A break in supply of surgical consumables may adversely affect our output for TT surgeries.

One TT surgeon should perform at least 120-200 surgeries per annum to maintain the surgical skill. Some surgeons may not meet this requirement to maintain their skills which may result in poor quality surgeries leading to higher refusal rates.

The backlog is an estimate of surgery needs and it is possible that the actual backlog of surgeries is much higher or lower.

There is a risk of accessibility to target communities in post conflict countries. There is both a sense of insecurity in such countries as well as poor infrastructure which will serve as constraints to programme expansion and increase costs.

3.4 Component A: Antibiotics

Ultimate Intervention Goal:

To reduce the prevalence of TF among 1 to 9 year olds to less than 5 percent in 24 Sightsavers supported countries by 2020.

Objective:

1. To expand antibiotic distribution to cover all districts with a TF prevalence of 10 percent or more by the end of 2017 and complete treatment by 2020 in the target countries.

Outputs:

1. 84 million people treated with Azithromycin annually for at least 3 consecutive years (total of 252,000,000 doses).
2. All endemic districts in the 24 countries covered by antibiotic treatment by 2017.
3. Baseline prevalence survey is carried out in all countries that need baseline assessment by 2015.
4. Repeat prevalence surveys are carried out after 3-5 years of antibiotic distribution depending on the baseline prevalence levels and therapeutic coverage.
5. Repeat prevalence surveys are carried out after three years of surveillance.

Activities:

An estimate for antibiotic requirements will be carried out by the Country Programme Managers at the Ministry of Health annually. The distribution of Azithromycin will be extended to all endemic districts in the countries. A monitoring system for the programme will also be established. The communities will be sensitized for mass treatment and resources-human and other resources will be mobilized.

Community based health workers together with community volunteers will do the treatment with antibiotics. In some countries, only health workers are allowed to treat people with antibiotics. This policy in these countries will be respected by the programme. In such cases, the community volunteers will participate in the sensitisation, social mobilisation and assist in activities during the distribution process.

All health staff and volunteers will be trained for mass antibiotic distribution and refresher training will be conducted before distribution each year. It is expected that 28,000 Health workers (40 per district) and 280,000 Volunteers (2 per community/400 per district) will be trained to carry out antibiotic distribution activities in the communities. Supervision and follow up and drug audits will be performed regularly

by senior Programme staff as well as external auditors (in the case of drug audits). Repeat prevalence surveys will be carried out in districts where the mass distribution has occurred for 3-5 consecutive years. A district level baseline prevalence survey will be carried out in countries that have not done so already by 2015. Depending on the results obtained, a treatment schedule will be outlined for the districts and countries. This, if necessary, will be done in the annual detailed implementation plan.

Table 9: Strategy for antibiotic treatment:

TF Prevalence Rate at the district level	Strategy
≥10%	Treat entire district for at least 3-5 consecutive years depending on baseline prevalence levels. Districts with prevalence rates of 30% or more would need to have at least 5 rounds of treatment.
5-9%	Assess sub-districts or communities and treat sub-districts or communities with TF≥5% If TF<5% treat affected children and their contacts e.g family members and play mates.

In a district with baseline TF prevalence of 10 percent or more in children 1 to 9 years, annual mass distribution of Azithromycin is indicated for at least 3 consecutive years. If the baseline is more than 30%, the district should receive at least 5 rounds of treatment before conducting an impact assessment survey. When the baseline TF prevalence at the district level is less than 10 percent an assessment will be done at the sub-district or community level. In sub-districts/ communities with TF prevalence of 5 percent or more, targeted treatment will be carried out for these sub-districts/communities. If TF prevalence rate at the community level is less than 5% percent we would consider treatment following the WHO guidelines of targeted treatments.

Depending on availability of funds, country policies and priorities, countries may decide how to manage districts with TF prevalence of less than 10% but would need to ensure that all endemic communities receive adequate treatment for elimination.

Eligible Population

Azithromycin should be made available to all residents in a targeted community except children less than 6months. Children under 6 months should be treated with tetracycline eye ointment. Pregnant women could be treated with Azithromycin, or provided with tetracycline eye ointment or counselled to come for treatment with Azithromycin after delivery of baby. Countries would need to decide on which direction to follow.

If mass treatment was indicated it would be continued for 3-5 years and then repeat prevalence survey is indicated. If TF drops under 5 percent in children 1 to 9 years old, antibiotic treatment is stopped. The antibiotic treatment coverage should be over 80 percent of the eligible population to achieve an impact. Country programmes should aim at reaching 95% coverage. To maintain gains made, other activities in F and E will be carried out and surveillance and monitoring system will be put in place by the taskforce at the district, regional and national levels.

Distribution of drugs

It is expected that Azithromycin will be provided free and donated to endemic countries by Pfizer through the International Trachoma Initiative. Drug storage and distribution to regions and districts will be done through the government existing channels within countries. The programme will strengthen the drug logistics and management systems in countries which do not have very strong systems in place. Drugs will be distributed

to community members at a time agreed upon by the managers of the programme at the district level and the community leaders.

Dosing

Dosing of the drugs will be done by height using a height/dose stick. Children under the age of 5 years will be provided with the suspension form of the drug and children above 5 years and adults will be provided with tablets.

Serious Adverse Events

All serious adverse events should be reported to any health personnel or at any health centre. A protocol as to what to do in case of any serious adverse event will be developed and provided to all frontline workers.

The new ITI Manual-Zithromax® in the Elimination of Blinding Trachoma- A Program Manager's Guide is a useful document that deals with almost all issues relating to Azithromycin distribution and it will be made available to all country programmes.

Expansion

Antibiotic treatment will be expanded to all 24 endemic countries and districts by 2017.

Number of people requiring treatments with antibiotics per country is shown in Table 10 below. WHO recommends the provision of a one full dose of Azithromycin to anyone who undergoes trichiasis surgery. 1% tetracycline eye ointment will be used to treat children under the age of 6 months. 2 tubes of Tetracycline ointment are also given to each person who undergoes trichiasis surgery. These should be borne in mind when countries are preparing their forecast for antibiotics.

Table 10: Countries- Population requiring antibiotics- confirmed, 50% of suspected & total

	Country	Number Confirmed Endemic Districts- need impact and surveillance surveys	Number Suspected Endemic Districts- need for baseline survey	Population requiring antibiotics- confirmed	Expected population needing antibiotics in confirmed +50% of suspected endemic population	Expected total population requiring antibiotics
1	Benin				94,019	94,019
2	Burkina Faso	30		7,205,383		7,205,383
3	Cameroon	13	23	1,744,698	1,225,407	2,970,105
4	CAR		21		119,499	119,499
5	Chad		8		2,457,015	2,457,015
6	Ghana	29	8			
7	Guinea	15		3,745,300		3,745,300
8	Guinea Bissau	20	38	191,338	669,585	860,923
9	Kenya	5	10	2,239,677	1,614,758	3,854,435
10	Malawi	2	8	1,311,420	930,587	2,242,007
11	Mali	10		1,179,501		1,179,501
12	Mozambique	3	72	151,788	6,551,884	6,703,672
13	Niger	23		9,274,849		9,274,849
14	Nigeria	79	209	18,091,360	21,691,891	39,783,251
15	Senegal	13	12	2,589,103	3,706,367	6,295,470
16	South Sudan	26	28	2,933,718	1,280,434	4,214,152
17	Sudan	3	37	546,240	5,229,099	5,775.339
18	Tanzania	43		9,906,874		9,906,874
19	The Gambia	7		120,698		120,695
20	Togo	No data				
21	Uganda	22	6	8,283,225	983,336	9,266,561
22	Zambia	5	36	2,162,140	3,076,284	5,238,424
	Sub-total	348	524	71,677,309	49,630,162	121,307,471
23	India	2	198	12,565,900	206,313,416	218,879,316
24	Pakistan		31		19,001998	19,001,998
	Sub-total	2	229	12,565,900	225,315,414	237,881,314
	Total	350	753	84,243,209	274,945,576	359,188,785

Risks and assumptions:

It has been assumed that current information received from countries from the situational analysis is accurate and that no great change is likely to occur over the next few years. We do not know what the actual prevalence rates of the districts yet to have baseline surveys done will be. We have however made an assumption that 50% of the suspected endemic districts will have trachoma that would require treatment. There is a risk that they may or may not have trachoma of the significance supposed in this strategic plan. These will have consequences on antibiotic needs which will be addressed in the annual detailed implementation plans.

It is also assumed that trachoma prevalence will drop below 5 percent in some of the communities and districts after 3 years of treatment and no further treatment will be needed after that. This has been shown in impact studies after 2 years of intervention where prevalence dropped below 5 percent in 80 percent of the communities. However, districts with very high levels of active trachoma- with TF of 30% or more may require more than 3 years of antibiotic treatment to attain a prevalence rate less than 5%. Some districts have also been noted to have brought down the rate of active trachoma to less then 5% with just about 2years of treatment.

It is assumed that Pfizer Inc. will provide Azithromycin to all people in trachoma endemic districts through ITI.

3.5 Component F: Face cleanliness

Ultimate Intervention Goal:

To have 80 percent of children aged 1 to 9 years with clean faces in endemic communities and districts by 2020.

Objectives:

1. To have at least 80 percent of children 1 to 9 years old with clean faces in endemic communities by 2020.
2. To intensify advocacy toward increased access to water and sanitation in all endemic communities including accessibility of these facilities to people who are blind and to people with other disabilities.

Outputs:

1. 80 percent of children 1 to 9 years have clean faces by 2020.
2. Access to water and facial cleaning materials are provided for all endemic communities by 2020 (Access is defined as not more than 30 minutes of walk to the safe water source; some countries/programmes use not more than 1 hour of walk time).

Activities:

Integrated behavioural change materials developed by Sightsavers with support by USAID and World Vision and in partnership with the NTD Control Programme in Ghana could be adapted and produced for use by other countries. The materials will be distributed for use by trained health workers, teachers, environmental health officers and other volunteers in communities and schools. IEC materials for mass media events which have been produced by other partners could be re-assessed and repackaged as needed and produced for the countries. Best practices such as radio learning clubs will be introduced to country programmes and adapted to be used in communities. The collaborative links among stakeholders will be strengthened and extended through regular meetings and information and resource sharing.

The School Health Education Programme in the countries will be strengthened through the training of teachers and provision of IEC materials to both teachers and school children by the NTD Programme in general and the Trachoma Control Programme in particular depending on programme strategy used in the country. Advocacy will be made by the various National Trachoma Control Taskforces and partners for trachoma to be included in the school curriculum of endemic countries. Trachoma awareness week will be celebrated

every year in the endemic countries. Monitoring and supervision will be carried out quarterly or as often as needed by managers of the programme at the National, Regional and District levels as well as the international level. Representatives of all stakeholders will be encouraged to carry out monitoring and evaluation roles as needed.

Risks and assumptions:

There is a risk that partners may provide water and sanitation facilities in areas where trachoma is not prevalent and postpone activities in endemic districts and communities. Wars can also impede the provision of developmental projects such as water and sanitation. We also need to note that behavioural change is a slow process and may take many more years to see the desired change. The programme must however continue to empower endemic communities to attain the desired behavioural changes. This is because the gains made from the treatment with antibiotics could be lost if endemic communities do not get the needed development in the provision of water and latrines and use them.

3.6 Component E : Environmental Change

Ultimate Intervention Goal :

Every endemic community to have access to at least one source of safe water and increase coverage and usage of household latrines by 25 percent by 2020 (Access to safe potable water – all year round potable water not less than 20 litres per capita per day within half a kilometre walking distance).

Objectives:

1. To make advocacy for 120,000 boreholes in endemic communities by 2020.
2. To make advocacy for 3 miliion household latrines in endemic communities by 2020.
3. To make advocacy to providers of these facilities to ensure accessibility of these facilities to people who are blind and to people with other disabilities.
4. To promote behavioural change.

Outputs:

1. Advocacy has been made for the provision of 120,000 boreholes by 2020 *(1 bore hole for 150-300 people, HDW 75-150, Piped system 2000-50,000).*
2. Advocacy has been made for the provision 3 million household latrines by 2020 (6 members per household).
3. Behaviours that need to be changed identified, targeted for elimination and desired behaviours encouraged.
4. Tools for IEC for desired behaviour produced.
5. Training of health workers, environmental health officers, teachers, and village health volunteers to provide IEC for desired behaviour done.
6. IEC sessions for community members held.

Table 11 Situational Analysis of countries for SAFE

	Country	Total number of confirmed and 50% of suspected endemic districts	Water Coverage	Household latrine coverage	Number of water points to be advocated for	Number of household latrines to be advocated for
1	Benin		60-79 (68)	12-58(32)	1000	50000
2	Burkina Faso	30	44-82 (51)	5-45 (12)	3000	100,000
3	Cameroon	25	41-84(63)	33-63(48)	1000	100,000
4	CAR	11	51-92(67)	28-43(34)	2000	40,000
5	Chad	4	32-40(34)	0-30(8)	5000	50,000
6	Ghana	33	64-88(75)	11-27(18)	2000	100,000
7	Guinea	15	70	34	8000	150,000
8	Guinea Bissau	39	49-79(59)	23-57(34)	4000	150,000
9	Kenya	10	46-89(62)	43-56(48)	8000	100,000
10	Malawi	6	62-96(67)	42-66(46)	5000	100,000
11	Mali	10	35-76(60)	39-59(45)	6000	200,000
12	Mozambique	39	24-76(42)	14-51(27)	5000	100,000
13	Niger	23	32-91(42)	3-27(7)	8000	200,000
14	Nigeria	184	49-72(60)	30-48(38)	8000	200,000
15	Senegal	19	54-90(72)	34-70(52)	8000	200,000
16	South Sudan	40	64-78(69)	24-50(34)	5000	100,000
17	Sudan	22	69.4	46	5000	150,000
18	Tanzania	43	17-64	83-95	8000	100,000
19	The Gambia	7	81-95(98)	23	1000	50,000
20	Togo		40-86(59)	3-24(12)	1000	50,000
21	Uganda	25	52-87(68)	39-53(41)	5000	80,000
22	Zambia	23	36-90(56)	39-53(41)	4000	80,000
	Sub total	610			93,000	245,000
23	India	101	84-96(88)	21-54(31)	15000	500,000
24	Pakistan	16	87-95(90)	35-92(54)	2000	50,000
	Sub total	117			17,000	550,000
	Total	727			120,000	3,000,000

Activities:

Advocacy activities will be carried out by the programme managers and partners at all levels for the provision of water and latrines. It is expected that both governments and non-governmental organisations especially those in the water and sanitation sector will commit themselves to achieving the goals for environmental improvement. Attaining these goals will greatly contribute towards the MDGs. The strategic plan advocates for the provision of boreholes and other safe water sources as well as household and school latrines in endemic communities by 2020. It is expected that both governments and development partners will work together to make these provisions as part of the efforts in reaching the Millennium Development Goals. The Sightsavers fast track initiative will make a contribution of providing 10,000 safe water points and 100,000 household latrines.

Advocacy will be made to providers of these facilities to ensure accessibility of these facilities to people who are blind and to people with other disabilities.

There is also the need to provide health education to promote hygiene and behavioural change for communities and households to have full benefits of this initiative. The community led total sanitation approach will be used. Communities will be expected to actively and fully participate in the planning and implementation of these facilities. Their ideas, and resource mobilisation in terms of funds, human resource (labour costs) and provision of local materials will go a long way to make the programme a success. Other resources will also be mobilized for the implementation of planned activities. A participatory rapid appraisal with stakeholders to identify undesirable behaviour will be conducted by the Country Programmes. Where needed, IEC materials will be adapted or developed, produced and distributed. Training will be carried out for health workers, environmental health officers, teachers, and village health volunteers to provide IEC. Community health education sessions will be carried out by trained personnel. Monitoring and supervision will be carried out by all stakeholders at various levels.

Risks and assumptions

This component is very expensive and the actual provision of water and improved sanitation will be carried out by other ministries, partners and stakeholders. It has been assumed that 30-50% of the endemic populations already have access to safe and adequate water supply. There may be less or more people without access to safe water. It is also assumed that communities will use these facilities when provided. Households need to be encouraged to participate fully – both labour and funds in the provision of these facilities to promote ownership and usage for the right purposes.

Many governments are committed to providing water and sanitation to meet the targets for MDGs. There are numerous partners of the Trachoma Control Programme and the NTDs Control Programme, who are also very much committed to this course. It is hoped that enough funds will be mobilized by all stakeholders so that this component will not suffer. Sightsavers will partner with key organisations including the media to strengthen the advocacy process.

3.7 Expansion of SAFE strategy

Currently, 350 districts in our target countries have been confirmed to have trachoma. 739 districts are suspected to have trachoma. It is expected that 50% of the suspected endemic districts will be confirmed to be endemic. Hence, an additional 372 districts are expected to be brought on board for SAFE implementation. It has therefore been estimated that the 24 endemic countries will have a total of 700 districts. By the end of 2015 an initial 350 districts are expected to have prevalence of TF below 5 percent and may be excluded from further treatment except in response to surveillance needs. The remaining districts will be covered by the end of 2017. It is assumed that trachoma prevalence will drop below 5 percent in some of the communities and districts after 3 years of treatment and no further treatment

will be needed after that. This has been shown in impact studies after 2 years of intervention where prevalence dropped below 5 percent in 80 percent of the communities in Ghana. However, in countries and districts where the prevalence of active trachoma is very high, it will take more than 3 years of treatment to reach a level of prevalence of active trachoma less than 5%. As part of the learning process, in some countries the strategy will be piloted in some districts to demonstrate the full SAFE strategy, the process of partnership for taking to scale, followed by scaling up, peaking of intervention districts, followed by a reduction in districts as the elimination succeeds and then plateau to a surveillance level. The ICTC INSight 2020 document has suggested a scenario for antibiotic scale up. This has been applied in our expansion plan as shown in Table 12 below.

Table 12: Scale up and expansion of antibiotic distribution

Year	Number of doses
2011	12,600,000
2012	25,200,000
2013	25,200,000
2014	37,800,000
2015	37,800,000
2016	37,800,000
2017	25,200,000
2018	25,200,000
2019	12,600,000
2010	12,600,000
Total	252,000,000

3.8 Monitoring and Evaluation

Monitoring and evaluation of the fast track initiative will be conducted over the ten year period by the managers of the programme at the international, national and district levels. Monitoring tools will be developed and used. Annual reviews and planning workshops will be conducted in each country to ensure that both quality and quantity expectations are met. The review meetings will also serve as a place for cross learning for districts. Changes that need to be made to meet new trends in programme management and elements of disease control will be made to ensure that there is effective and efficient use of available resources. International meetings will be held periodically to help towards cross learning for countries.

3.9 Research and Learning

Research and learning will be an integral part of this initiative. There will be links of research to demonstration models; monitoring and evaluation and research will work together to ensure models are robust and effective before getting others to take the programme up. Research questions and topics of importance to the programme will be developed by the Research and Learning team together with the Fast Track Initiative teams of Sightsavers. Some research issues to look at include:

- To what extent do investments in implementing the full SAFE strategy contribute to strengthening health systems.
- Benefits of integrating trachoma control activities with other health interventions.
- To what extent is NGO support needed during surveillance and preparation towards certification.

Both basic and operational research work will be carried out to provide information for evidence based interventions. Where needed, consultants will be brought on board to provide assistance in conducting research. Results of these research works will be disseminated to all stakeholders and learning acquired will be applied to the programme.

3.10 Surveillance and Certification

Districts and countries which have reached their UIGs will be assisted to establish a surveillance system according to the WHO guidelines. Each district or country that has reached its UIGs is required to implement surveillance activities over a 3 year period. A repeat survey will have to be conducted afterwards and then based on the results the process for certification can begin.

4.0 Partner collaboration

Sightsavers has a large number of partners implementing the SAFE strategy in endemic districts in the Sightsavers supported countries. The Ministries of Health in the various countries will be the key partner championing overall programme implementation and coordination. Other Ministries besides MOH supporting trachoma control include the Ministry of Education, Ministry of Local Governments and Ministries for community development. Members of the ICTC are all partners and each brings its expertise to country programmes to ensure success in programme planning, implementation, monitoring and evaluation.

UN-organisations such as the WHO and UNICEF are key partners. Sightsavers also works in strong partnerships with corporate bodies in the private sector such as the Standard Chartered Bank. Most of the major partners are listed below in table 13.

Table 13: Bilateral Organisations, UN Agencies and Non-governmental partners working in trachoma control

Partner	Roles
Ministries of Health	Overall coordination
Ministries of Education	School health and hygiene promotion
Ministries of Water	Provision of Water
Ministries of Local Government	Provision of sanitation
DFID	Funding
USAID	Funding and technical support
Standard Chartered Bank	Funding
RTI	Funding and technical support
The Carter Center	Provision of surgery; F&E activities
International Trachoma Initiative	Provision of Zithromax® and technical support
UNICEF	Provision of water and sanitation in schools
WaterAid	Provision of water and sanitation
WHO	Training of health workers, advocacy and technical support
Lion's Club	General support for eye care, advocacy
Swiss Red Cross	Support for surgery
CBM	Support for surgery
Operation Eye Sight Universal	Support for surgery
Fred Hollows Foundation	Support for SAFE
HKI	Support for surgery, antibiotic distribution
OPC	Support for SAFE
Islamic Relief	Provision of water, sanitation facilities and hygiene promotion

Partner	Roles
Eau Vive	Provision of water and sanitation
World Vision International	Provision of water and sanitation
DANIDA	Provision of water
Collin Glasco Foundation	Provision of water
Check Dev. Agency	Provision of water
D-WASHE	Provision of water
Oxfam	Provision of water and sanitation
DAPP	Provision of water
Concern Universal	Provision of water and sanitation facilities and hygiene promotion
Action Aid	Provision of water and sanitation
Amref	Provision of water and sanitation
Lion Aid Norway	Eye Health
MITOSATH	Support for surveys and workshops
Adventist Development Relief Agency	Provision of water and sanitation
Fresh Water	Provision of water
HRDS	
Active Citizen Participation Programme of British Council	
Children's Fund	Provision of water and sanitation in schools

Rotary Club and Lions Club are potential partners. The partners will be encouraged to collaborate in the implementation of different aspects of the SAFE strategy. Assistance is needed in distribution of antibiotics, clearing the backlog of TT cases and in improvement of water and sanitation.

It is expected that for the purposes of integration and scaling up, the Ministries of Health will take the lead role in overall coordination for partners. Sightsavers will provide the needed technical and some financial support. Trachoma Control Taskforces will be set up at the national, regional and district levels. All partners at the various levels will be encouraged to be well represented and participate fully in the formulation of policies and provide inputs for programme planning, implementation and evaluation as well as providing inputs for various levels of integration and collaboration with various activities under the SAFE strategy and with the NTDs Control Programme.

5.0 Budget

The full programme costs for the Sightsavers' fast track initiative for the elimination of blinding trachoma is $190 million. The average per year is $19million for the 24 targeted countries. The range is from $13.7million to $23.8 million depending on the activities to be carried out in a particular year. This amount excludes the cost for the provision of hardware for water and latrines.

The calculated budget includes the components of the SAFE strategy, but excludes the cost of Azithromycin because it is provided free by Pfizer Inc to endemic countries. The national programmes will require both financial and technical support for all SAFE components.

The budget for gathering data- baseline as well as for impact and surveillance surveys comes to a total of $13 million. The following were used to make inputs for the budget:

1. Baseline district surveys – $5,000 per district survey for 753 districts.
2. Impact surveys – $7,500 per impact survey per district for 725 districts.
3. Surveillance surveys – $6,000 per surveillance programme per district for 725 districts.

Budget for countries to develop national level strategic plans is nearly $2 million.

The 10 year budget calculation of the surgery component of $40 million indicates a cost of $40 per TT surgery for 1 million surgeries. Unit cost for TT surgery is expected to be much less in hyper-endemic areas and be slightly more in meso to hypo endemic areas.

The budget for the antibiotic component includes all other costs except the drug cost. The budget for the 10 year period comes to $63million with a range of $3 -$9 million depending on the number of districts to be treated in a particular year. A total of 84 million people are expected to benefit from antibiotic treatment. It is assumed that each one will need about 3 doses. 252,000,000 doses of antibiotics are expected to be distributed. The average cost per distribution per person is $0.25.

The budget for facial cleanliness is $35 million for 10 years. Average yearly budget comes to $3.5 million. The programme will thus be making a contribution of about $5,000 per district per year for the 700 districts targeted.

The environmental change component is the most expensive including the construction of clean water sources and the construction of latrines in endemic communities. The total cost is $140 million. The programme has made a budget of $20,000 per programme district per year for 700 districts. Currently, it is not in the plan for the fast track initiative to provide funds for the entire provision of safe water source and latrine construction, but only for IEC activities, supervision and monitoring and for water and latrines hardware for demonstration purposes. Clearly more funds are needed to meet the full cost of the provision of water and latrines; a multi-sectoral collaboration is needed for funding of this component.

An amount of $24,000 has been budgeted annually for basic and operational research. The total for the 10 year period comes to $240,000.

The assumptions used in providing the budget estimates were largely based on activities to be carried out as per the requirements of personnel, fuel and other logistics. Previous detailed implementation plans and approved budgets were looked at to provide basis for projections based on actual targets and realistic expenditures. Government and WHO rates and directives were largely used as basis for calculating the budget estimates. The actual details will be provided in the detailed implementation plan which will be done yearly.

Table 14: Budget lines for Programme costs implementing SAFE strategy for 2011-2020

	Admin & Cap. Items (USD)	Total SAFE Program Cost (USD)	Total Admin, Cap. & Program (USD)	Water and Latrine Construction (USD) (contribution)
2011	1,295,800	12,414,250	13,710,050	14,000,000
2012	1,318,490	16,927,250	18,245,740	14,000,000
2013	1,403,315	18,365,000	19,768,315	14,000,000
2014	999,895	20,254,000	21,253,895	14,000,000
2015	989,122	20,305,250	21.294,372	14,000,000
2016	1,587,196	22,231,500	23,818,696	14,000,000
2017	1,711,855	18,941,500	20,653,355	14,000,000
2018	1,694,724	18,032,750	19,727,474	14,000,000
2019	1,191,850	14,286,500	15,478,350	14,000,000
2020	1,254,824	14,881,500	16,136,324	14,000,000
Total	13,447,071	176,239,500	189,686,571	140,000,000

The detailed calculation of the budget can be found in Annex 2

Logical framework

Logical framework of the fast track elimination of blinding trachoma strategic plan for 24 countries in Africa and Asia 2011-2020

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
Vision		24 Sightsavers supported countries in Africa and Asia free from blinding trachoma.			
UIG		Eliminate blinding trachoma in 24 countries in Africa and Asia by the year 2020.	<5 percent prevalence of TF cases in 1 to 9 year olds, <1 TT case/1000 population.	Survey reports	2020
Data gathering					
UIG		All 24 countries to have current population based survey data (baseline, impact and surveillance survey data).	Number of countries with current population based survey data.	Programme reports	2011-2020
Objective	1	To conduct baseline surveys in 739 trachoma suspected endemic districts in the 24 countries.	Number of districts with baseline survey data.	Survey reports	2011-2014
Output	1	Baseline prevalence surveys in 739 districts carried out.	Number of districts with baseline survey data.	Survey reports	2011-2014
Activities		Conduct baseline surveys in 739 districts.	Number of districts with baseline prevalence data.	Survey reports	2011-2014
Objective	2	To conduct impact surveys in 725 programme districts in 24 countries.	Number of programme districts with impact survey data.	Survey reports	2012-2020
Output	2	Impact surveys carried out in 725 programme districts.	Number of programme districts with impact survey data.	Survey reports	2012-2020
Activities		Conduct impact surveys in 725 programme districts.	Number of programme districts with impact survey data.	Survey reports	2012-2020

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
Objective	3	To conduct surveillance surveys in 725 districts on reaching their UIG.	Number of programme districts with surveillance data.	Survey reports	2013-2020
Output	3	Surveillance surveys carried out in 725 programme districts on reaching their UIG.	Number of programme districts with surveillance data.	Survey reports	2013-2020
Activities	1	Conduct surveillance survey in 725 districts.	Number of districts with surveillance survey data.	Survey reports	2011-2020
Multi-year National strategic plans for Trachoma					
UIG		All 24 Countries to have a national multi-year strategic plan document for the elimination of blinding trachoma by 2013.	Number of countries with Country Strategic Plans available.	National strategic plan for trachoma documents	2011-2013
Objective		To provide support to countries without a strategic plan for trachoma to develop a multi-year strategic plan document for the elimination of blinding by 2013.	Number of countries supported to develop strategic plans.	Workshop reports	2011-2013
Outputs		Countries have national multi-year strategic plan for the elimination of blinding trachoma.	Number of countries with Country Strategic plans available.	Country strategic plan, reports	2011-2013
Activities	1	Conduct a technical group workshop to prepare a draft strategic plan.	Number of workshops held.	Workshop reports	2011-2013
	2	Conduct a stakeholders meetings for their inputs and finalisation of the strategic plan.	Number of stakeholders meetings held.	Meeting reports	2011-2013
Objective	2	To provide support to countries with multi-year strategic plans to conduct a midterm or end of term evaluation of their country plans.	Number of countries supported to conduct review of their country plans.	Evaluation reports	2011-2015

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
Output	2	Countries with strategic plans in place; have had their plans evaluated and necessary changes effected.	Number of countries with revised strategic plans.	Revised strategic plans	2011-2015
Activities	1	Conduct a mid-term or end of term evaluation of country strategic plans for trachoma.	Number of midterm/ end of term reviews carried out.	Review reports	2011-2015
	2	Conduct a technical group workshop to make the necessary amendments to strategic plans.	Number of strategic plans reviewed.	Workshop reports	2011-2015
	3	Conduct a stakeholders workshop for their inputs and finalisation of the strategic plan.	Number of strategic plans finalised.	Finalised plans, reports	2011-2015
Component S: Surgery					
Objective	1	To clear the backlog of TT surgeries in 24 countries in Africa and Asia by 2020.	Number of TT operations, number of TT cases/1000 population in each of the 24 Countries.	TT surgery register, surveys	2020
Output	1	1,000,000 TT cases operated by 2020.	Number of TT operations performed.	TT registers	2020
Activities	1	Train 14,000 health workers and 140,000 volunteers for case detection.	Number of health workers and volunteers trained.	Training report	2011-2020
	2	Develop a service delivery manual for surgical services.	Surgery manual.	Document	2011
	3	Create awareness for surgery using mass media, community durbars, child to child, child to parents/ grandparents information.	Number of IEC sessions conducted for different groups.	Reports	2011-2020

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
	4	Organise systematic TT case search in endemic communities.	Number of cases identified Number of communities screened for TT cases.	Reports	2011-2020
	5	Train 1000 new TT surgeons and certify surgeons (300 in 2011; 400 in 2012; 400 in 2013).	Number of TT surgeons trained and certified.	Reports	2011-2013
	6	To provide refresher training for 200 TT surgeons per year from 2014.	Number of TT surgeons given refresher training.	Reports	2014-2020
	7	Operate TT cases: between 30,000-165,000 either in eye camps or static facilities annually- to a total of 1,000,000 cases.	Number of TT cases operated annually; number of eye camps annually.	TT surgery book; reports	2011-2020
	8	Provide logistics for surgery (14,400 surgical kits, 3,600 sterilizers, consumables for 1,000,000 TT surgeries etc.).	Number of equipment and consumables provided.	Inventory register	2011-2020
Objective	2	To maintain TT recurrence rate below 10 percent.	Percentage recurrences.	Reports	2011-2020
Output	2	Recurrence below 10 percent per surgeon.	Percentage recurrences by surgeon.	TT register TT recurrence survey report	2011-2020
Activities	1	Develop standard guidelines.	Standard guidelines.	Documents	2011
	2	Maintain TT register.	Up to date TT register.	TT register	2011-2020
	3	Follow-up of operated cases (day 2 and day 8).	Percentage of operated cases followed according to guide.	Reports	2011-2020
	4	Perform surgical audit.	Number of comprehensive audits per year.	Reports	2012-2020
	5	Operations research (survey for TT recurrences) annually.	Number of TT surveys conducted.	Reports	2012-2020

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
Component A: Antibiotics					
UIG		Reduce the prevalence of TF among 1 to 9 year olds to less than 5 percent in 24 Sightsavers supported countries in Africa and Asia by 2020.	Percentage of children aged 1 to 9 years with TF in endemic communities less than 5 percent.	Survey reports	2015-2020
Objective	1	To expand antibiotics distribution to cover all trachoma endemic districts with a TF prevalence of 10 percent or more in 24 countries by the end of 2020.	Geographical coverage; percent of communities achieving at least 80 percent coverage in mass distribution .	Antibiotics registers, monthly/ quarterly/ annual reports	2011-2020
Output	1	Population in endemic districts in 24 countries treated annually for at least 3 consecutive years.	Percentage of eligible population treated.	Antibiotics registers reports	2011-2020
	2	All endemic communities/districts in 24 countries covered for antibiotic treatment by 2017.	Percentage of communities covered with over 80 percent treatment coverage in eligible population.	Antibiotics registers, monthly/ quarterly/ annual reports	2011-2010
	3	Baseline prevalence surveys in endemic districts conducted and repeat surveys carried out after 3 years.	Percentage of children aged 1 to 9 years with TF in endemic districts in 24 countries.	Survey reports	2011-2020
	4	Repeat prevalence surveys carried out after three years of surveillance activities.	Percentage of children aged 1 to 9 years with TF in endemic districts in 24 countries.	Survey reports	2013-2020
Activities	1	Baseline prevalence surveys in 24 countries (about 700 districts).	Number of districts surveyed.	Survey report	2011-2016
	2	Impact and surveillance surveys in 700- (350 confirmed endemic and another 350 out of the 700 suspected endemic districts).	Number of districts/ countries with surveys done.	Survey report	2011-2016

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
	3	Training for antibiotic distribution 28,000 health workers and 280,000 volunteers to be trained.	Number of health workers and volunteers trained.	Training Report	2011-2020
	4	Estimate and monitoring system for antibiotic needs.	Number of districts/ communities with prevalence of TF > 5 percent in children aged 1 to 9 years; quantity of antibiotics needed annually.	Survey report, report on drug requirements	2011-2020
	5	Treatment with antibiotics: Total population of 84million people treated.	Percentage of eligible population treated.	Antibiotics distribution registers, monthly/ quarterly/ annual reports	2011-2020
	6	Community mobilisation & sensitisation.	Proportion of endemic districts/communities mobilised and sensitised.	Reports	2011-2020
	7	Distribution of Antibiotics.	Number of people treated with antibiotics annually. Proportion of eligible population treated. Quantities of antibiotics distributed annually.	Reports	2011-2020
	8	Supervision and follow-ups.	Number of supervisory visits.	Reports	2011-2020
	9	Drug audit.	Number of doses of antibiotic used, in stock and expiry information.	Evaluation report	2011-2020
Component F: Facial Cleanliness					
UIG		At least 80 percent of children 1 to 9 years have clean faces in endemic communities.	Percentage of children with clean faces.	Survey reports	2014-2020

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
Objective	1	To increase awareness on trachoma prevention (facial cleanliness) in all endemic communities/ districts of the 24 countries to 80 percent from its 2011 level by 2020.	Percentage of persons with basic knowledge in village.	Survey reports	2011;2014 2017 & 2020
Output	1	At least 80 per cent of children 1 to 9 years in 24 endemic countries have clean faces by 2020.	Percentage of children with clean faces.	Survey reports	2011-2020
Activities	1	Develop, produce and distribute IEC materials for use by health workers, teachers, environmental health officers and other volunteers in communities and schools.	Number of new materials developed and number of materials distributed.	Stores receipt voucher	2012 & 2016
	2	Develop and produce IEC materials for use in mass media events to all endemic districts.	Number of new materials developed and Number of materials distributed.	Stores receipt voucher	2012 & 2016
	3	Train and retrain 28,000 health workers, environmental health officers, teachers and 280,000 village health volunteers to provide IEC on SAFE in each district.	Number of people trained.	Training reports	2011-2020
	4	Health workers, environmental health officers, teachers and other volunteers to provide community education on facial cleanliness and identify and refer trichiasis cases for surgery.	Percentage of communities covered.	Monthly data reports/ surveys	2011-2020

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
	5	Provide IEC using the mass media (Radio &TV panel discussions, jingles) in English and major local languages 16 weeks in a year.	Number of programmes or sessions aired over projected number.	Monthly data reports	2011-2020
	6	Organise trachoma awareness week celebration/events at national level.	Number of countries where Trachoma Week was celebrated.	Annual reports	2011-2020
	7	Organize 1 community durbar per district per year.	Number of community durbars organised/ targeted number.	District quarterly and annual report	2011-2020
	8	Expand radio learning clubs to 50 purposively selected endemic communities per country per year each year.	Number of radio learning clubs functioning/number targeted.	District/ country reports	2011-2020
	9	Community selected persons to moderate and monitor radio learning groups.	Number of teachers trained and assigned; number of radio learning groups facilitated by teachers.	Monthly reports	2011-2020
	10	Monitor and supervise activities of Environmental Health Officers, Community Health Nurses & Disease Control Officers monthly by DDHS/Reps.	Number of monitoring visits.	Monitoring reports.	2011-2020
Objective	2	To intensify advocacy towards increased access to water and sanitation in all endemic communities.	Percentage of communities demanding services; number of meetings/ consultations/briefing sessions on providing access to facilities for facial cleanliness.	Minutes and reports	2011-2020
Output	2	Advocacy for increased water provision and improved sanitation facilities in endemic communities.	Number of advocacy meeting sessions held/ percent of communities having access to water.	Minutes of meetings monthly reports	2011-2020

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
Activities	1	Extend and strengthen the collaborative links among stakeholders through regular meetings and information and resources sharing.	Number of meetings held.	Meeting minutes	2011-2020
	2	Monitor and supervise activities of Environmental Health Officers, Community Health Nurses & Disease Control Officers monthly by DDHS/Reps.	Number of monitoring visits done.	Monitoring reports	2011-2020
Component E: Environmental change					
UIG		Every endemic community to have access to at least one source of safe water and increase coverage of household latrines by 25 percent (contribute 10,000 safe water sources and 100,000 household latrines) by 2020.	Proportion of communities with access to at least one source of safe water. Proportion of households with latrine.	Surveys	2011-2020
Objective	1	To make advocacy for the provision of 1,000 boreholes (BH) and other safe water sources in endemic communities per year for 10 years by 2020.	Number of advocacy sessions held; number of BH and small town systems available and functioning.	Advocacy meeting reports; monitoring reports, surveys, field visits	2011-2020
Outputs	1	1,000 BH and other safe water sources provided per year.	Number of BH and other safe water sources functioning.	Monitoring reports, surveys, field visits	2011-2020
Activities	1	Resource mobilisation.	Resources available.	Contract documents, MOUs, commitment letters	2011-2020

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
	2	Implementation (mobilisation, siting, completion of facilities, etc.	Number of facilities available.	Field visits, monitoring reports	2011-2020
	3	Monitoring and supervision.	Number of monitoring/ supervisory visits.	Field visits, monitoring reports	2011-2020
Objective	2	To provide 10,000 latrines per year in 24 countries for the next 10 years.	Number of latrines provided and in-use in the 24 countries annually.	Monitoring reports, surveys, field visits	2011-2020
Output	2	10,000 household latrines provided to endemic communities in 24 countries per year for the next 10 years.	Percentage of latrines completed and in-use; percent of households with latrines.	Field visits, monitoring reports	2011-2020
Activities	1	Resource mobilisation.	Resources available.	Contract documents, MOUs, commitment letters	2011-2020
	2	Implementation (mobilisation, siting, lining, completion of facilities, etc.	Number of facilities available.	Field visits, monitoring reports	2011-2020
	3	Monitoring and supervision.	Number of monitoring/ supervisory visits.	Field visits, monitoring reports	2011-2020
Objective	3	To promote behavioural change.	Percentage of community members practicing safe hygiene.	Monitoring reports, KAP studies, field visits	2011-2020
Output	1	Behaviours that need to be changed identified and targeted for elimination.	Number of high risk behaviours targeted.	Reports surveys	2012;1017
	2	Tools for IEC for desired behaviour produced and training done.	Number of tools produced and training sessions held.	Training reports records	2012;2017

		Intervention Logic	Objectively Verifiable Indicators	Source of verification	Time frame
		Training of health workers, environmental health officers, teachers, village health volunteers to provide IEC for desired behaviour done.	Number of people trained.	Reports records	2011-2020
	3	IEC sessions held.	Percentage of planned sessions held; number of participants.	Reports	2011-2020
Activities	1	Conduct a Participatory Rapid Appraisal with stakeholders to identify undesirable behaviour in 24 countries.	Number of PRA sessions conducted.	Report	2012
	2	IEC material review, development & production.	Number IEC materials available.	Records and reports	2013
	3	Train health workers, environmental health officers, teachers, village health volunteers.	Number of people trained.	Training reports	2011-2020
	3	IEC sessions for communities and households.	Number of IEC sessions held.	Reports	2011-2020
	4	Monitoring and supervision.	Number of monitoring/ supervisory visits.	Field visits, monitoring reports	2011-2020

Annexes

Annex 1 – Results on SWOT exercise on SAFE strategy implementation

Strengths

- Baseline data available in most of the countries.
- Availability of partners for the provision of surgery.
- Availability of international and local NGOs in the water and sanitation sector.

Challenges

- Exact backlog of TT cases is not known-exact number not really known, figure extrapolated from district surveys.
- Inadequate number of surgeons-this needs to be addressed by the training of more TT surgeons.
- Ensuring availability of and provision of water and sanitation facilities in endemic areas.
- No trachoma plan or programme in some countries.
- Absence of baseline data in some countries.
- No behavioural change materials in some countries.
- Nomadic/seasonal migration of community members.
- Skewed distribution of TT surgeons in some countries- More surgeons to be trained and certified specially for districts without TT surgeons.
- Some countries do not yet have access to the Pfizer-donated Zithromax.

Opportunities

- Pfizer's commitment to provide donated Zithromax to endemic countries through ITI.
- Availability of partners and their commitment towards GET 2020.
- Integration of the Trachoma Program with the Neglected Tropical Diseases Control Programme especially in the area of MDAs.
- Possible integration of Trachoma Control Programme with Malaria Control Programme.
- Governments and partners commitment towards the achievements of the MDGs.
- Availability of community volunteers.
- Integrated approach to disease surveillance.
- Mainstreaming facilities in schools.
- Existence of School Health Education Programme in some countries.
- Availability of developed IE&C Materials which can be adapted for other countries.

Threats

- Ethnic conflicts in a few program areas.
- Competing programmes.
- Resource requirement for baseline surveys at the community level for meso-hypo endemic districts.
- Resource requirement for post 3-year assessment.
- Over-reliance on external support by governments.
- Insecurity (e.g. ethnic strife, armed robbers).
- High cost of water supply.
- Poverty.
- Natural disasters e.g. floods, droughts.

Sightsavers fast track initiative for elimination of blinding trachoma

Budget summary 2011-2020 in USD

Intervention Logic

Vision 24 Countries in Africa and Asia free of blinding trachoma

UIG Fast Track Elimination of blinding trachoma in 24 Countries by the year 2020

Description	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total ($)
Budget Summary											
Administration & Capital Equipment											
Capital Equipment	560,000	500,000	500,000	66,000	-	550,000	622,000	550,000	-	-	3,348,000
Administration	735,800	818,490	903,315	933,895	989,122	1,037,196	1,089,855	1,144,724	1,191,850	1,254,824	10,099,071
Total Administration and Capital Equipment	1,295,800	1,318,490	1,403,315	999,895	989,122	1,587,196	1,711,855	1,694,724	1,191,850	1,254,824	13,447,071
Programme (without hardware-water & latrines)											
Data gathering	941,250	1,850,000	2,395,250	2,395,250	1,454,000	1,454,000	1,454,000	545,250	545,250	545,250	13,579,500
Country Strategic Plans	-	-	-	275,000	375,000	375,000	275,000	275,000	375,000	375,000	2,325,000
Surgery	2,587,000	3,041,250	3,933,750	2,397,750	3,290,250	5,216,500	5,176,500	5,176,500	4,480,250	5,075,250	40,375,000
Antibiotics	3,150,000	6,300,000	6,300,000	9,450,000	9,450,000	9,450,000	6,300,000	6,300,000	3,150,000	3,150,000	63,000,000
Facial Cleanliness	3,540,000	3,540,000	3,540,000	3,540,000	3,540,000	3,540,000	3,540,000	3,540,000	3,540,000	3,540,000	35,400,000
Environmental improvement (contribution for hardware)	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	140,000,000
Monitoring & Evaluation and Surveillance	2,172,000	2,172,000	2,172,000	2,172,000	2,172,000	2,172,000	2,172,000	2,172,000	2,172,000	2,172,000	21,720,000
Research and Learning	24,000	24,000	24,000	24,000	24,000	24,000	24,000	24,000	24,000	24,000	240,000
Total Programme with water & latrines hardware	26,414,250	30,927,250	32,365,000	34,254,000	34,305,250	36,231,500	32,941,500	32,032,750	28,286,500	28,881,500	316,639,500
Total SAFE (without hardware-water & latrines)	12,414,250	16,927,250	18,365,000	20,254,000	20,305,250	22,231,500	18,941,500	18,032,750	14,286,500	14,881,500	176,639,500
Total Capital/Administration/ Program	13,710,050	18,245,740	19,768,315	21,253,895	21,294,372	23,818,696	20,653,355	19,727,474	15,478,350	16,136,324	190,086,571
Total Cost of Provision of Water and Latrines (Hard Ware)	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	14,000,000	140,000,000
Grand Total Cap/Admin/ Program/Water & Latrines)	27,710,050	32,245,740	33,768,315	35,253,895	35,294,372	37,818,696	34,653,355	33,727,474	29,478,350	30,136,324	330,086,571

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