Sightsavers

Quality standards manual: defining minimum effective practice for Sightsavers supported programmes

www.sightsavers.org

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Community Directed Treatment with Ivermectin, Hore Fello, Guinea

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Foreword

Sightsavers strategic objectives are set out clearly in our SIM card, a version of the balanced scorecard. The SIM card drives everything we do, and is available on our website. One of our objectives is to ensure our programmes are of high quality. Given our aims to demonstrate scalable, cost effective approaches to enable systemic change, this is clearly fundamental. Nobody will replicate a programme that cannot show it is high quality.

Our work ultimately centres on beneficiaries, and they have the right to high quality services. In eye health this is particularly critical as poor quality can be hazardous and can even lead to irreversible blindness. All the work we do around system strengthening, advocacy and capacity building must also be of high quality if it is to be effective. It is therefore critical that Sightsavers commits itself to quality, and the development of these quality standards is part of that commitment.

This manual sets out the quality standards that we expect our programmes to achieve. We will be assessing our programmes, our country offices and our partners against these standards, and will be developing plans for improvement as part of our commitment to quality.

Dr Caroline Harper OBE

Chief Executive, Sightsavers

September, 2012

Abbreviations and acronyms

AA	Advocacy Alliance
ALB / MEB	Albendazole / Mebendazole
APOC	African Programme for Onchocerciasis Control
ATO	Annual Treatment Objective
BCC	Behavioural Change Communication
BPO	Blind Persons Organisation
CAT	Capacity Assessment Tool
CBR	Community Based Rehabilitation
CDD	Community Directed Distributors
CDTI	Community Directed Treatment with Ivermectin
CMP	Commitments Management Panel
CPD	Continuous Professional Development
CSO	Civil Society Organisation
DIP	Detailed Implementation Plan
DPO	Disabled Persons Organisation
ESWG	Education Sector Working Group
FAT	Financial Assessment Tool
FLHF	Front Line Health Facilities
GCR	Geographic Coverage Rates
GET	Global Elimination of Trachoma
HMIS/MIS	Health / Management Information System
IAPB	International Agency for the Prevention of Blindness
IDA	International Development Agencies
IEC	Information, Education and Communication
IEP	Individual Education Plan
IOL	Intraocular lenses
LVD	Low Vision Device

MDA	Mass Drug Administration
MEC	Mectizan® Expert Committee
MoH	Ministry of Health
MOU	Memorandum of Understanding
NTD	Neglected Tropical Disease
OPD	Out Patients Department
PCM	Programme Cycle Management
PDA	Programme Development Advisor
PFA	Programme Funding Agreement
PoC CA	Point of Care Circulating Cathodic Antigen
PZQ	Praziquantel
QSAT	Quality Standards Assessment Tool
RAAB	Rapid Assessment of Avoidable Blindness
RAPLOA	Rapid Assessment for Loa loa
RD	Regional Director
RDQA	Routine Data Quality Audit
REMO	Rapid Epidemiological Mapping of Onchocerciasis
SAE	Severe Adverse Events
SAFE	Surgery, Antibiotics, Facial Cleanliness, Environmental Improvement
SIM CARD	Strategy Implementation and Monitoring Card
TCR	Therapeutic Coverage Rates
TF	Active Trachoma
ToR	Terms of Reference
TQS	Thematic Quality Standards
TT	Trachomatous Trichiasis
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UTG	Ultimate Treatment Goal
WASH	Water, Sanitation and Hygiene
WATSAN	Water and Sanitation
WHO	World Health Organisation

Introduction

Ensuring high quality programmes is one of Sightsavers strategic objectives[1]. In response to this, in 2009 Sightsavers developed a four pronged quality improvement strategy[2] constituting an improved monitoring and evaluation (M&E) system, learning framework, technical assistance framework, and a programme quality improvement framework - a core component of which was the development of quality standards that capture effective practices in our areas of work.

Although Sightsavers does not implement any programmes directly, it has a responsibility to ensure that the programmes it is selecting, supporting, funding and managing are of high quality. These standards therefore act as a reference point against which a programme may be evaluated[3], both to assure staff that programme management decisions are being made in keeping with identified sector best practices, and to demonstrate that all efforts are being made to mitigate harm to beneficiaries, and deliver the best possible outcomes in line with Sightsavers vision and mission.

Meeting a standard means meeting the minimum level that all Sightsavers programmes are expected to reach. Our commitment to their compliance contributes to our organisational accountability, and is crucial in installing confidence in Sightsavers from the public, donors, partners and the beneficiaries which we work with and for.

These standards will be evaluated periodically to ensure they remain relevant and consistent with new developments and recommendations.

[1] Sightsavers, 2009. Strategic Framework 2009-2013: Making the Connections [online]. Available at: http://www.sightsavers.org/about_us/ publications/9690_Strategic%20Framework.pdf [Accessed 2 July 2012].
[2] Sightsavers, 2009, Towards High Quality Programmes in Sightsavers: Quality Improvement Strategy 2009-2013.
[3] See HAP, 2012. What is a standard [online]. Available at: http://www.hapinternational.org/standards.aspx [Accessed 2 July 2012].

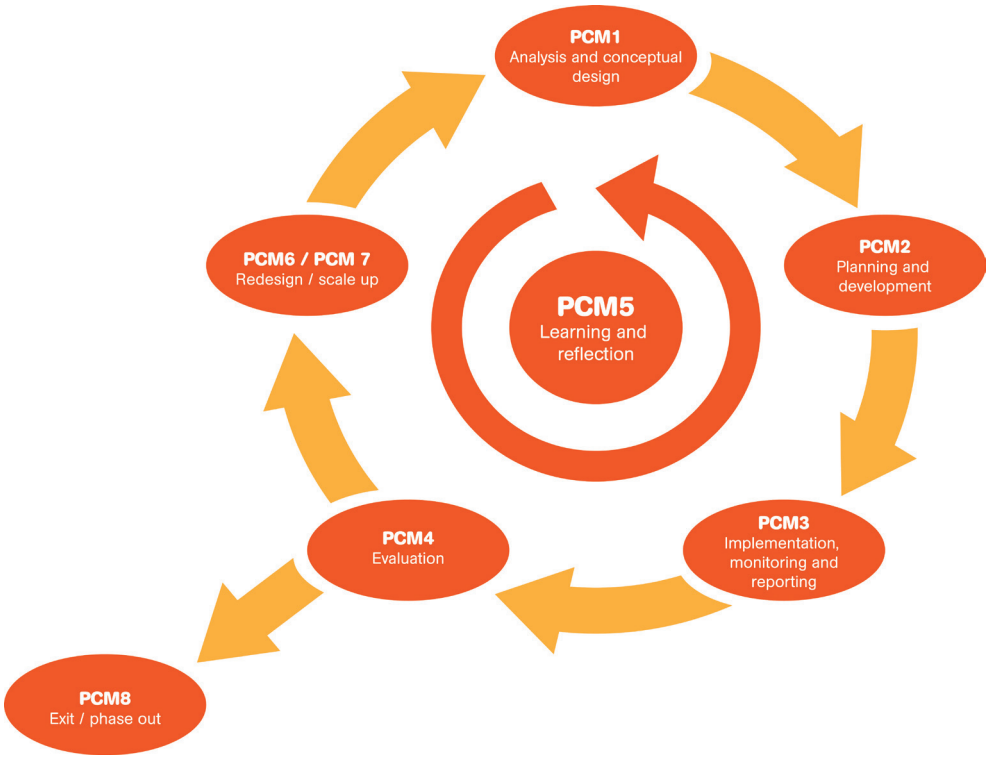
Format

Following a comprehensive consultation process, standards have been developed for the following areas of our work:

Programme cycle management (PCM):

The programme cycle management (PCM) quality standards represent the cycle through which a programme progresses from its inception to its end - see figure one for a conceptualisation of this process. Note that learning and reflection encircle the cycle - this is to demonstrate the importance ascribed by Sightsavers to learning and reflection at all stages.

Figure one: Programme cycle management based improvement



As the programme cycle management quality standards are the basis of programme development and management, it is **mandatory** that Sightsavers country / area offices embed these standards in all programme work.

Thematic quality standards (TQS):

The thematic quality standards (TQS) have been developed based on international best practice in core areas of Sightsavers work:

HSBB	Health system building blocks
HReH	Human resources for eye health
LVS	Low vision services
TRA	Trachoma
ONC	Onchocerciasis
RES	Refractive error services
CAS	Cataract services
EDU	Education
SOI	Social inclusion
LF	Lymphatic filariasis
SCH	Schistosomiasis
STH	Soil transmitted helminths

As the thematic quality standards (TQS) inform programmatic interventions, partner organisations are encouraged to embed these standards in their programmatic work. Sightsavers understands and appreciates that many countries and partners have established, or are establishing, standards for the thematic areas that Sightsavers supports. Sightsavers therefore recognises that in the countries where we work, host-government or partner standards should take precedence - our standards are to support our work with partners, and not to cause conflict or competition for them. However, in circumstances / instances where we find that a proposed partner's standards do not meet the minimum standards as outlined in this manual, no contract should be signed or implementation started until any discrepancies are resolved.

Standards in all technical areas are similarly formatted, with a benchmark, a set of requirements, means of verification, and (for the thematic quality standards), a statement of relevance:

Benchmark: The aspired state or level that our programmes should attain in each standard.

Requirements: Individual minimum expectations that each programme needs to practice / put in place in order to meet the quality standard.

Means of verification: The evidence needed to verify that each requirement has been met. These means of verification may take form of a review of documentation, site visits / observations of practice, or interviews.

Statement of relevance: This clarifies the applicability of each of the standards to three core audiences - beneficiaries, Sightsavers partners and professionals.

Application

Quality improvement is an on-going process, and the application of these standards will therefore be phased:

For all new projects (2013) and beyond): Sightsavers and partner staff proposing and developing new projects will…

- Use this manual as a reference point when developing new partnerships and projects.
- Explicitly embed all the requirements of the programme cycle management standards, and the respective thematic standards in the project.
- Include the application of the quality standards assessment tool (QSAT) in monitoring activities.

On-going projects: Sightsavers and partner staff will use these standards to realign on-going projects by…

- Utilising when on-going projects come up for renewal.
- Discussing with partners as to how the standards will be incorporated into their on-going work.
- Including the application of the quality standards assessment tool (QSAT) in monitoring activities.

Furthermore:

- Technical experts will use the respective programme cycle and thematic standards to guide the provision of technical assistance.
- Consultants or staff undertaking evaluations of on-going interventions (formative and summative), will use the respective programme cycle and thematic standards to guide their assessment.

Country / area offices should identify strategic opportunities to introduce the relevant thematic standards to partners in advance of an assessment exercise.

Opportunities to introduce the standards may include:

- During the development of a new partnership formulated around a specific project or programme
- Renewal of memoranda of understanding (MOUs) / programme funding agreements (PFA).
- Progress review / monitoring visits.
- Learning and sharing events.
- Evaluations.
- Any specific meeting that will discuss a component of the standards.

Should a partner already have standards in place, the Sightsavers standards should be used to identify gaps and verify that the minimum expected of all Sightsavers supported projects is in place.

Assessment

A quality standards assessment tool (the QSAT) has been developed to provide a quantitative baseline against which a country office / partner organisation may be re-assessed. These quantitative results will provide the evidence base against which Sightsavers can demonstrate to the public, its donors, partners and beneficiaries that it is an organisation dedicated to quality improvement.

Undertaking an assesment in programme cycle management

The PCM standards enable Sightsavers county / area offices to objectively appraise the quality of their programme development and management processes. Assessment is conducted in relation to the total number of projects within the portfolio of a county / area office (a mechanism within the PCM assessment form will randomly assign one project for assessment per PCM standard as is relevant). The compliance of a country / area office to each standard is calculated based on aggregated scores for all related requirements - each requirement may be rated as 'not met', 'partially met, 'mostly met', 'fully met' or 'not applicable' based on a review of the necessary evidence (means of verification).

Ratings link to a scoring mechanism which designates the need for quality improvement per standard, and for a technical area as a whole. Relative need is designated as 'critical', 'strong', 'moderate' or 'low'.

Undertaking an assessment in the thematic quality standards

The TQS standards enable objective appraisal of Sightsavers supported projects (through assessment of each relevant partner organisation in the appropriate thematic standards). The compliance of a partner organisation to each standard is calculated based on the aggregated scores for all related requirements - each requirement may be designated as 'not met', 'partially met', 'mostly met', 'fully met' or 'not applicable' based on a review of the necessary evidence (means of verification).

Ratings link to a scoring mechanism which designates the need for quality improvement per standard, and for a technical area as a whole. Relative need is designated as 'critical', 'strong', 'moderate' or 'low'.

The output of a QSAT exercise is an action plan for continuous quality improvement (the expertise of professional bodies / experts in country may be sourced to help assess the technical soundness of this plan). Re-assessment should take place after an ascribed period to track the implementation of agreed actions. The period of time between initial assessment and re-assessment will be informed by the team undertaking the initial assessment. Where the initial quality assessment raises concerns in critical areas, immediate remedial action may be needed and therefore re-assessment may be scheduled soon after the remedial action has taken place.

For further details on the QSAT including all necessary support guidance, see the QSAT website.

Treatment of child with antibiotics for trachoma, Kigweri, Uganda.

Trachoma standards

Trachoma is caused by the bacterium *Chlamydia trachomatis*. Infection causes conjunctivitis, irritating the eyes and causing a mucous discharge which may then spread infection to others through direct contact, through towels / handkerchiefs, or via eye-seeking flies. After years of repeated infection, the inside lining (conjunctiva) of the eyelid may be so severely scarred that the upper eyelid margin turns inwards causing the eyelashes to scratch the eyeball. The scratching of the eyelashes on the eyeball causes irreversible scarring, leading to blindness[11].

Trachoma infection is symptomatic of poverty, poor sanitation, and the lack of hygienic controls associated with a lack of water to regularly wash hands and faces[12]. Efforts to control trachoma are aligned under the WHO global elimination of trachoma by 2020 (Get 2020), and the neglected tropical diseases (NTD) initiatives, and are based on the WHO endorsed SAFE strategy (Surgery, Antibiotics, Facial cleanliness, Environmental improvement). All Sightsavers trachoma control programmes conform to the GET 2020 standards and are consistent with the SAFE approach[13].

Our icon depicts an eye encircled with barbed wire, and as such is representative of the pain experienced by people infected with trachoma.

[11] See WHO, 2012. Prevention of Blindness and Visual Impairment: Priority Eye Diseases - Trachoma [online]. Available at: http://www.who.int/blindness/causes/priority/en/index2.html [Accessed 2 July 2012].
[12] See Sightsavers, 2012. How Trachoma spreads [online]. Available at http://www.sightsavers.org/our_work/how_we_help/health/causes_of_blindness/trachoma/16914.html [Accessed 2 July 2012].
[13] See Sightsavers. 2011. Elimination of Blinding Trachoma: Ten year strategic fast tracking plan in 24 countries - November, 2011 [online]. Available at http://www.sightsavers.org/our_work/how_we_help/health/causes_of_blindness/trachoma/17872_Eliminating%20trachoma%2010%20year%20tracking%20plan.pdf [Accessed 2 July 2012].

This technical area comprises the following standards:

TRA1	Service delivery
TRA2	Health workforce
TRA3	Infrastucture and technology
TRA4	Medical products and equipment
TRA5	Patient and provider safety
TRA6	Programme effectiveness

TRA1 Service delivery

Benchmark: Community directed treatment programmes are supported by effective and sustainable drug procurement and delivery mechanisms to front line health facilities (FLHF), and ultimately to communities.

Requirements		Means of verification
TRA 1.1	Timely and sufficient azithromycin / tetracycline eye ointment is effectively ordered, cleared at in-country customs, stored, monitored and distributed within the government system.	• ITI Zithromax request forms • Procurement and stores records
TRA 1.2	Programmes should ensure that endemic communities receive at least the appropriate rounds of antibiotics depending on the baseline prevalence of active trachoma among children 1-9 years old.	• Country trachoma action plan • MDA report
TRA 1.3	Community directed distributors (CDDs) collect azithromycin / tetracycline eye ointment from the nearest health facility.	• Store records (indication of collection by health workers / CDDs) • Interview with project staff
TRA 1.4	Treatment takes place at a time, and using a mode of distribution decided by the national programme and the community.	• Annual programme report • Interview with project and community members
TRA 1.5	Community members and decision makers understand the benefits and are committed to long term treatment with azithromycin / tetracycline eye ointment.	• Annual programme report • Independent monitoring and sustainability evaluation reports
TRA 1.6	Mass drug administration (MDA) programme coverage is not less than 90%.	• MDA report • Post-MDA coverage survey report
TRA 1.7	Each patient should is provided with one dose of azithromycin immediately after trichiasis surgery.	• ITI Zithromax request forms • Surgery reports
TRA 1.8	Trichiasis surgery campaigns should be planned to make effective and efficient, and lead to at least 20 surgeries (eyes) operated on by each surgeon per day.	• Trichiasis surgery reports • Trichiasis surgical statistics
TRA 1.9	Patients declining to have surgery after counselling are given the opportunity to have epilation and be trained on how to conduct epilation effectively.	• Trichiasis surgery reports

TRA 1.10	Treatment for trachoma is co-implemented with other interventions, e.g. NTD, child health campaigns and WASH, where appropriate, and need exists.	• WHO progress report • Interview with project staff and CDDs

Audience	Statement of relevance
Beneficiaries / communities	Can expect sufficient drug supplies to be distibuted effectively. Communities are committed to treatment to protect against trachoma.
Sightsavers partners	Sufficient supplies of azithromycin / tetracycline eye ointment should be distributed at locations and at times agreed with the community.
Health professionals	Ensure appropriate and effective ordering and distribution systems for azithromycin / tetracycline eye ointment (which have been agreed with communities) are in place.

TRA2 Health workforce

Benchmark: The necessary number and cadre mix of qualified, motivated, productive and competent workforce is deployed to trachoma endemic areas, consistent with population health needs and service demands.

Requirements		Means of verification
TRA 2.1	Complete trachoma treatment teams are in place to cover registration, dosing, dispensing and recording of antibiotic coverage programmes.	• Programme / service plans • Training records
TRA 2.2	One supervisor is in place per five to ten antibiotic treatment teams, to check on correct dosage, dispensing, recording of coverage, drug expiry dates, serious adverse events (SAE) etc.	• Programme / service plans
TRA 2.3	Twenty front line and community workers to provide behavioural change communication (BCC) promotion in facial and environmental cleanliness are in place per district.	
TRA 2.4	Drug distributors, supervisors and BCC workers have received the necessary materials to conduct health, education and social mobilisation campaigns to raise awareness and ensure high treatment uptake.	• Annual programme report • Interview with project staff and CDDs / drug distributors
TRA 2.5	Surveillance staff with the relevant skills for epidemiological surveillance are available and supported where the need exists.	• Programme / service plans • Surveillance reports

TRA 2.6	Candidates for trichiasis surgery training should have good binocularity, near and distance vision, and be able to pass a simple test of manual dexterity such as suturing an orange skin.	• Trichiasis surgery training reports • Eye test reports of trichiasis surgeons
TRA 2.7	Trichiasis surgeons have completed a standardised training module for trichiasis surgery, and are certified according to WHO guidelines.	• Training curriculum • Interview with head of department / manager
TRA 2.8	Trichiasis surgeons undergo regular supportive supervision by a senior surgeon / trainer, and a refresher course every one to two years.	• Supervision and course reports
TRA 2.9	The availability of trichiasis surgeons should approximate to two surgeons per district with an average population of one hundred and twenty to two hundred thousand. Surgeons should perform at least two hundred trichiasis surgeries per annum to maintain skills.	• Programme delivery and resource plans • Surgical / staff records

Audience	Statement of relevance
Beneficiaries / communities	Can expect the appropriate range and number of qualified, well managed staff to be available to provide a quality serivce.
Sightsavers partners	Trachoma programmes should be staffed by the necessary number of competent staff, including for surveillance where necessary
Health professionals	Ensure appropriate supervision and team resourcing for trachoma programmes.

TRA3 Infrastructure and technology

Benchmark: Trichiasis surgeries take place within appropriately constructed and maintained facilities, using the appropriate technology.

Trichiasis surgery may be conducted during community outreach or in medical facilities. The following standards should be adhered to when operating during outreach:

Requirements		Means of verification
TRA 3.1	The operating room should be located at an acceptable distance for patients to travel (ideally at a health facility or other appropriate location in the community).	• Site visit for inspection • Interview with service provider
TRA 3.2	The operating room should be clean (no dust or cobwebs), well lit and spacious.	

When surgery is conducted at a medical facility, the following standards should be adhered to:

Requirements		Means of verification
TRA 3.3	The out patients department (OPD) is well ventilated, with a waiting area that has sufficient sitting space for patients and carers, and is maintained to an acceptable level of cleanliness and hygiene.	• Site visit for inspection • Cleaning records and guidelines
TRA 3.4	The OPD contains sufficient hand washing facilities in each clinic for staff, appropriate sanitary facilities for staff, patients and carers, and dust covers for all medical equipment.	
TRA 3.5	Operating theatre design and patient movement / flow allows for, and meets, acceptable levels of barrier protection against infection.	• Site visit for inspection
TRA 3.6	Operating theatre surfaces and fixtures are made of suitable materials that minimise retention of dirt and dust, and allow for proper cleaning and disinfection.	• Site visit for inspection • Cleaning records and guidelines
TRA 3.7	The operating theatre is suitably equipped with tables for surgical cases.	• Site visit for inspection

Audience	Statement of relevance
Beneficiaries / communities	Can expect facilities to be clean, comfortable, well located and appropriate. Patients and carers can leave with the confidence that they are safe from cross infection and other potential negative effects.
Sightsavers partners	Services should be housed in clean, comfortable, well located and appropriate facilities.
Health professionals	Ensure that their work is delivered in appropriate facilities which meet the specific current clinical safety and quality guidelines, and enable efficient, confidential and safe service delivery.

TRA4 Medical products and equipment

Benchmark: Sufficient trichiasis kits, sterilisers, consumables, antibiotics, environmental management technologies and modes of transport are available.

Requirements		Means of verification
TRA 4.1	At least three complete trichiasis kits and one functioning steriliser are available per surgeon.	• Inspection of equipment

TRA 4.2	Equipment is in good working order and is regularly serviced / assessed. A functioning system is in place for replacement when necessary.	• Inspection of equipment • Equipment maintenance records
TRA 4.3	Consistent supply of recommended medicines and consumables.	• Clinical records and supply log
TRA 4.4	Local anaesthetic drug Lidocaine 2% with adrenaline is available for use with patients. Plain Lidocaine 2% is available for patients with high blood pressure or hypertension.	
TRA 4.5	Functional and supervised ordering, storage, monitoring and distribution system for medicines and consumables is in place.	• Stock register • Inspection of inventory
TRA 4.6	Environmental management technology (e.g. wells, pumps, refuse disposal items, latrines etc.) for water supply and basic environmental sanitation are available and functioning.	• Programme reports • Evidence of collaboration with WATSAN or equivalent partners
TRA 4.7	Motorcycles and vehicles for field work are available, in good working order, and are regularly serviced. A functioning system is in place for replacement when necessary.	• Inspection of motorcycles and vehicles • Service record book • Procurement reports

Audience	Statement of relevance
Beneficiaries / communities	Can expect a range of medical supplies and other key equipment to be available.
Sightsavers partners	A range of medical supplies should be reliably available to the trachoma control programme.
Health professionals	Ensure that supply systems work effectively to maintain stock levels of medical supplies.

TRA5 Patient and provider safety

Benchmark: Patient and provider safety protocols that are consistent with appropriate accepted standards are in place and complied with, including a preoperative checklist to reduce risk, infection control policy, and staff safety and protection policy.

Requirements		Means of verification
TRA 5.1	Informed consent is obtained for all trichiasis surgical cases.	• Patient records • Observation of surgery

[14] An infection control policy should be inclusive of the design of the operating theatre complex and patient flow within, sterilisation procedures and technology, and infection control in the ward and outpatient department. See WHO., 20004. Practical Guidelines for Infection Control in Health Care Facilities [online]. Available at http://www.searo.who.int/LinkFiles/Publications_PracticalguidelinSEAROpub-41.pdf [Accessed 2nd July 2012].

[15] See WHO, 2005. Protecting Healthcare Workers: Preventing Needlestick Injuries Toolkit [online]. Available at http://www.who.int/occupational_health/activities/pnitoolkit/en/index.html [Accessed 2nd July 2012].

TRA 5.2	Prior to undergoing surgery, the relevant eye is clearly marked, and is confirmed by the patient as the eye to be operated.	• Observation of surgery
TRA 5.3	Blood pressure is checked before listing for surgery.	• Patient records • Observation of surgery
TRA 5.4	Patients receive counselling which includes risks / complications of surgery and consequences of not undergoing surgery.	• Observation of surgery
TRA 5.5	The operating team should have an infection control policy that complies with international / national standards[14].	• Infection control policy (ensure a live process with clarity on actions when a critical incident / near miss occurs)
TRA 5.6	Staff compliance with the infection control policy is high and routinely monitored.	• Infection control policy monitoring reports • Observation of surgery
TRA 5.7	A staff safety and protection policy is in place that includes the disposal of potentially contaminated items (e.g. for where a patient is HIV+), and a policy on needle stick injuries, that complies with international / national standards[15].	• Staff safety and protection policy
TRA 5.8	Staff compliance with the staff safety and protection policy is high and routinely monitored.	• Staff safety and protection policy monitoring reports • Observation of surgery
TRA 5.9	A card indicating potential side effects of drugs used and what needs to be done in event of side effects is available at all levels.	• Laminated protocol available and visible to staff.

Audience	Statement of relevance
Beneficiaries / communities	Can expect the risks and complications of trichiasis surgery to be minimised.
Sightsavers partners	Effective measures are in place to protect patients and staff from the risks associated with trichiasis surgery.
Health professionals	Ensure their practice is consistent with protocols in place to minimise surgical risks to their patients, themselves and their colleagues.

TRA6 Programme effectiveness

Benchmark: Programmes are well planned, comprehensive, of verifiable quality, are monitored, consistent with SAFE, and integrated with NTDs, school health and community development activities.

Requirements		Means of verification
TRA 6.1	Mechanisms are in place to ensure that no persons are denied access to trachoma control services (for example, due gender, sexuality, poverty, disability, nomadic lifestyle or internal displacement).	• Project proposal and detailed implementation plan (DIP) • Evidence of interview with beneficiaries from marginalised groups
TRA 6.2	A clear comprehensive trachoma control plan which aims at reaching elimination by a set date with adequate funding across SAFE elements is in place.	• Trachoma elimination resource plan
TRA 6.3	Effectively functioning trachoma control taskforces / committees exist at different levels.	• Taskforce / committee membership • Meeting reports
TRA 6.4	A locally appropriate management information system (MIS) consistent with WHO, GET and NTD formats is in place and supplies necessary and timely information.	• MIS and reports
TRA 6.5	Monitoring of trachoma programmes includes the attainment of annual treatment objectives (ATOs), gender equity (especially of surgery), and recurrence rates of trichiasis aginst agreed standards / targets.	• MIS reports and surveillance forms
TRA 6.6	Treatment with azithromycin / tetracycline eye ointment and trichaisis surgery is free to eligible populations in endemic areas.	• Policy document or statement
TRA 6.7	A protocol exists and is followed for informing patients of / managing treatment related side-effects and/or serious adverse events in line with Ministry of Health (MoH) and WHO requirements.	• Adverse drug reaction protocol
TRA 6.8	Independent post-MDA coverage surveys are undertaken for comparison against reported programme coverage.	• Coverage surgey report
TRA 6.9	Patient follow-up should include recording rates of post operative TT, granuloma, lid-closure defect, notching, and contour abnormality and patient satisfaction	• Patient records

TRA 6.10	An MDA communication plan is in place before MDA is started.	• MDA communication plan
TRA 6.11	Impact monitoring is conducted to measure reduced prevalence and intensity of infection following the least required number of treatment rounds with MDA, consistent with the following elimination targets: • TF of less than five per cent in children aged one to nine. • TT of less than one in one thousand in adults aged fifteen and above.	• Impact assessment survey / report
TRA 6.12	Post-operative trichiasis recurrence rate is less than 10%	• TT recurrence rate survey reports
TRA 6.13	Identified population needs for trachoma elimination are integrated into wider NTD and health / development programmes.	• National strategic plan / NTD Masterplan • Programme plans and reports

Audience	Statement of relevance
Beneficiaries / communities	Can expect an effective, integrated and comprehensive programme to be in place.
Sightsavers partners	A well planned, adequately resourced, integrated, comprehensive programme (consistent with SAFE) should be in place, with on-going monitoring of key aspects.
Health professionals	Ensure that professional activities to eliminate trachoma (consistent with SAFE) are effectively delivered, integrated and monitored.

Measuring individuals for correct Mectizan® dosage, Kachia, Kaduna, Nigeria.

Onchocerciasis standards

Onchocerciasis is a parasitic disease caused by the nematode *Onchocerca volvulus*, transmitted through the bite of different blackfly species. In Africa these are mostly members of the *Simulium damnosum* complex. The disease is commonly known as river blindness, as the parasite-transmitting blackflies infest fertile riverside areas, and is a result of infection by adult female worms which produce high numbers of microfilariae (first-stage larvae) that cause intense itching[16]. When these microfilariae die, the reaction of an infected person's immune system causes inflammation - should this happen in the eye, it can cause blindness[17].

Sightsavers adopts the strategies and quality standards of the WHO African Programme for Onchocerciasis Control (APOC), and supports the community directed treatment with Ivermectin (CDTI) approach[18].

Our icon depicts a river - the environment in which onchocerciasis is prevalent, and the blackfly - the agent of disease transmission.

[16] See WHO, 2012. Prevention of Blindness and Visual Impairment: Priority Eye Diseases - Onchocerciasis (river blindness) [online]. Available at: http://www.who.int/blindness/causes/priority/en/index3.html [Accessed 2 July 2012].
[17] See Sightsavers, 2012. What is River Blindness [online]. Available at: http://www.sightsavers.org/our_work/how_we_help/health/causes_of_blindness/river_blindness/16974.html [Accessed 2 July 2012].
[18] See Sightsavers, 2011, Elimination of onchocerciasis: Ten-year strategic fast tracking plan in Sightsavers supported countries 2011-2021 [online]. Available at http://www.sightsavers.org/our_work/how_we_help/health/causes_of_blindness/river_blindness/17651_Ten%20year%20plan%20to%20eliminate%20river%20blindness.pdf [Accessed 2 July 2012].

This technical area comprises the following standards:

ONC1	Service delivery
ONC2	Health workforce
ONC3	Programme effectiveness

ONC1 Service delivery

Benchmark: Community directed treatment with Ivermectin (CDTI) programmes are supported by effective and sustainable drug procurement and delivery mechanisms to front line health facilities (FLHF), and ultimately to communities.

Requirements		Means of verification
ONC 1.1	Timely and sufficient Ivermectin is effectively ordered, cleared at in-country customs, stored, monitored and distributed within the government system.	• Programme / service plans • Procurement and stores records
ONC 1.2	Community directed distributors (CDDs) or community members collect Ivermectin from the nearest health facility.	• Store records (indication of collection by CDDs / community members) • Interview with programme staff and community members
ONC 1.3	Treatment takes place at a time, and using a mode of distribution decided by the national programme and community.	• Annual programme report • Interview with programme staff and community members
ONC 1.4	Community members and decision makers understand the benefits and are committed to long term treatment with Ivermectin.	• Annual programme report • Independent monitoring and sustainability evaluation reports from APOC
ONC 1.5	Treatment for onchocerciasis is co-implemented with other interventions, e.g. NTD, child health campaigns and WASH, where appropriate, and need exists.	• WHO progress report • Interview with programme staff and and drug distributors

Audience	Statement of relevance
Beneficiaries / communities	Can expect sufficient drug supplies to be distributed effectively. Communities are committed to treatment to protect against onchocerciasis.
Sightsavers partners	Sufficient supplies of Ivermectin are distributed at locations and at times agreed with the community.
Health professionals	Ensure appropriate and effective ordering and distribution systems for ivermectin - which have been agreed with communities - are in place.

ONC2 Health workforce

Benchmark: The necessary number and cadre mix of qualified, motivated, productive and competent health staff and CDDs, who are knowledgeable and skilled in CDTI, are deployed consistent with population health needs and service demands.

Requirements		Means of verification
ONC 2.1	Two / three CDDs have been trained / re-trained in the community directed treatment strategy, preventative measures and serious adverse events (SAE) per community of two hundred and fifty members using the APOC CDTI curriculum, as well as dose poles and treatment registers.	• Programme / service plans • Training records
ONC 2.2	Selected FLHF staff in community directed treatment areas have been trained as CDD supervisors using the APOC CDTI curriculum to check on correct dosage, dispensing, recording of coverage, drug expiry dates, SAE etc.	
ONC 2.3	Drug distributors and supervisors have received the necessary materials to conduct health education and social mobilisation campaigns to raise awareness and ensure high treatment uptake.	• Annual programme report • Interview with programme staff and CDDs / drug distributors
ONC 2.4	Surveillance staff with the relevant skills for entomological and epidemiological surveillance are available and supported where the need exists.	• Programme / service plans • Surveillance reports

Audience	Statement of Relevance
Beneficiaries / communities	Can expect health professionals and community partners to be skilled and knowledgeable in drug treatment for onchocerciasis (including side effects).
Sightsavers partners	Onchocerciasis programmes should be staffed by the necessary number of competent staff, including for surveillance where necessary.
Health professionals	Ensure that they, their professional colleagues and community partners are competent in the delivery of CDTI programmes.

ONC3 Programme effectiveness

Benchmark: Projects consistently achieve annual geographical coverage rates (GCR) and therapeutic coverage rates (TCR), as recommended by APOC. An ultimate treatment goal (UTG) is defined, and monitoring and evaluation requirements are agreed.

Requirements		Means of verification
ONC 3.1	Mechanisms are in place to ensure that no persons are denied access to onchocerciasis elimination services (for example, due to gender, sexuality, poverty, disability, nomadic lifestyle or internal displacement).	• Project Proposal / detailed implementation plan (DIP) • Evidence of interviews with beneficiaries from marginalised groups
ONC 3.2	Rapid epidemiological mapping of onchocerciasis (REMO) and community censuses have been carried out prior to drug treatment to identify communities in need of treatment, and inform the agreement of a UTG.	• REMO map • Annual programme report
ONC 3.3	Rapid assessment for Loa loa (RAPLOA) has been carried out where onchocerciasis and Loa loa are co-endemic prior to Ivermectin drug treatment, in accordance with Mectizan® expert committee (MEC) guidelines.	• REMO and RAPLOA maps (ascertain areas of overlap)
ONC 3.4	Effectively functioning NTD control taskforces / committees exist at different levels.	• Taskforce / committee membership • Meeting reports
ONC 3.5	A locally appropriate management information system (MIS) consistent with WHO and NTD formats is in place and supplies necessary and timely information.	• MIS and reports
ONC 3.6	Annual treatment with Ivermectin is carried out consistent with a GCR of one hundred per cent and TCR of eighty per cent as recommended by APOC.	• Annual programme report
ONC 3.7	Treatment with Ivermectin is free to eligible populations in endemic areas.	• Policy document or statement
ONC 3.8	A protocol exists and is followed for informing patients of / managing treatment related side-effects and / or serious adverse events in line with Ministry of Health (MoH) and WHO requirements.	• Adverse drug reaction protocol
ONC 3.9	Independent post-mass drug administration (MDA) coverage surveys are undertaken for comparison against reported programme coverage.	• Coverage survey report

ONC 3.10	Impact monitoring is conducted to measure reduced prevalence and intensity of infection in treated areas following treatment rounds.	• Impact assessment survey / report
ONC 3.11	A transmission assessment survey has been conducted in districts as applicable to confirm that MDA should be stopped.	• Transmission assessment survey
ONC 3.12	Identified population post treatment surveillance needs for onchocerciasis elimination are integrated into wider NTD and health / development programmes.	• National strategic plan / NTD Masterplan • Programme plans and reports

Audience	Statement of relevance
Beneficiaries / communities	Can expect an effective, integrated and comprehensive programme consistent with APOC recommendations to be in place.
Sightsavers partners	A well planned, adequately resourced, integrated, comprehensive programme that is consistent with APOC recommendations should be in place, with on-going monitoring of key aspects.
Health professionals	Ensure that professional activities to eliminate onchocerciasis are consistent with APOC recommendations, and are effectively delivered, integrated and monitored.

Community distributor delivering medication door to door for lymphatic filariasis, Wum, Cameroon

Lymphatic Filariasis

Lymphatic filariasis is a chronic infection caused primarily by the filarial parasite *Wuchereria bancrofti*, transmitted through the bite of the mosquito. The disease is most commonly recognised by its most severe manifestation - elephantiasis, and is a result of infection by worms that live in the lymphatic system that produce high numbers of microfilariae. Lymphatic filariasis has a wide spectrum of disease - some individuals may be asymptomatic with no external sign of infection (although there will be damage to the lymphatic system, kidneys and immune system), others may experience acute inflammation of the skin, lymph nodes and lymphatic vessels i.e. *hydrocele testis*, *lymphedema* and in some cases elephantiasis (approximately forty per cent of sufferers will experience these). Although these inflammatory symptoms are not often fatal, they are a leading cause of permanent and long-term disability, and the psychological wellbeing of sufferers may be damaged due to isolation and stigma[23].

The transmission of Lymphatic filariasis may be interrupted through the mass drug administration of anthelminitic drugs and vector control interventions such as long-lasting insecticide treated nets.

Our icon depicts stage sevenelephantiasis in the lower leg, and the mosquito - the agent of disease transmission.

Our quality standards for lymphatic filariasis were developed in collaboration with Dr. Benjamin Koudou of the Liverpool School of Tropical Medicine.

[23] Hoetz, P.J., 2013. Forgotten People, Forgotten Diseases: The Neglected Tropical Diseases and their Impact on Global Health and Development. 3rd ed. Washington: ASM Press.

This technical area comprises the following standards:

LF1	Service delivery
LF2	Health workforce
LF3	Programme effectiveness

LF1 Service delivery

Benchmark: Community directed treatment with Ivermectin / Diethylcarbamazine and Albendazole are supported by effective and sustainable drug procurement and delivery mechanisms to front line health services, and ultimately to communities.

Requirements		Means of verification
LF 1.1	Timely and sufficient Ivermectin / Diethylcarbamazine and Albendazole are effectively ordered, cleared at in-country customs, stored, monitored and distributed within the government system.	• Programme / service plans • Procurements and stores records
LF 1.2	Community directed distributors (CDDs) or community members collect Ivermectin / Diethylcarbamazine and Albendazole from the nearest health facility.	• Store records (indication of collection by CDDs / community members) • Interview with programme staff and community members
LF 1.3	Treatment takes place at the time, and using a mode of distribution decided by the national programme and community.	• Annual programme report • Interview with programme staff and community members
LF 1.4	Community members and decision makers understand the benefits and are committed to long-term treatment with Ivermectin / Diethylcarbamazine and Albendazole.	• Annual programme report • Independent monitoring and sustainability evaluation reports
LF 1.5	Treatment for lymphatic filariasis is co-implemented with other interventions, e.g. NTD, child health campaigns and WASH, where appropriate, and need exists.	• WHO progress report • Interview with programme staff and drug distributors

Audience	Statement of relevance
Beneficiaries/ Communities	Can expect sufficient drug supplies to be distributed effectively. Communities are committed to treatment to protect against lymphatic filariasis.
Partners	Sufficient supplies of ivermectin / diethylcarbamazine and albendazole should be distributed at locations and at times agreed by the national programme and community.
Health Professionals	Ensure appropriate and effective ordering and distribution systems for ivermectin / diethylcarbamazine and albendazole (which have been agreed with communities) are in place.

LF2 Health workforce

Benchmark: The necessary number and cadre mix of qualified, motivated, productive and competent health staff and community directed distributors (CDDs), who are knowledgeable and skilled in community directed treatment with Ivermectin / Diethylcarbamazine and Albendazole, are deployed consistent with population health needs and service demands.

Requirements		Means of verification
LF 2.1	A minimum of one CDD has been trained / re-trained in the community directed treatment strategy, preventative measures, morbity management and disability prevention, and series adverse events (SAE) per community of three hundred members using Ministry of Health (MoH) guidelines, as well as dose poles and treatment registers.	• Programme / service plans • Training records
LF 2.2	Selected front line health facility (FLHF) staff in community directed treatment areas have been trained as CDD supervisors to check on correct dosage, dispensing, recording of coverage, drug expiry dates, SAE etc.	
LF 2.3	Drug distributors and supervisors have received the necessary materials to conduct health education and social mobilisation campaigns to raise awareness and ensure high treatment uptake.	• Annual programme report • Interview with project staff and CDDs / drug distributors
LF 2.4	Surveillance staff with the relevant skills for entomological and epidemiological surveillance are available and supported where the need exists.	• Programme / service plans • Surveillance reports
LF 2.5	Hydrocele surgeons have completed a standardised training module for hydrocele surgery, and are certified according to WHO guidelines.	• Training curriculum • Interview with head of department / manager
LF 2.6	Hydrocele surgeons undergo regular supportive supervision by a senior surgeon / trainer and undertake a refresher course periodically.	• Supervision and course reports
LF 2.7	FLHF are fully trained in WHO approved lymphoedema management practices.	• Training curriculum • Interview with head of department / manager

Audience	Statement of relevance
Beneficiaries/ Communities	Can expect health professionals and community partners to be skilled and knowledgeable in drug treatment for lymphatic filariasis (including side effects).
Sightsavers Partners	Lymphatic filariasis programmes should be staffed by the necessary number of competent staff, including for surveillance where necessary.
Health Professionals	Ensure that they, their professional colleagues, and community partners are competent in the delivery of lymphatic filariasis programmes.

LF3 Programme effectiveness

Benchmark: Countries should consistently achieve geographical coverage rates (GCR) and therapeutic coverage rates (TCR) as recommended by WHO. Mass drugs administration is carried out annually and impact is measured through monitoring and evaluation surveys carried out until microfilariae rate <1%. Monitoring and evaluation requirements targeting lymphatic filariasis elimination are agreed.

Requirements		Means of verification
LF 3.1	Mechanisms are in place to ensure that no persons are denied access to lymphatic filariasis elimination services (for example, due to gender, sexuality, poverty, disability, nomadic lifestyle or internal displacement).	• Project proposal / detailed implementaiton plan (DIP) • Evidence of interviews with beneficiaries from marginalised groups
LF 3.2	Mapping activities using appropriate diagnostic tools and community censuses have been carried out prior to drug treatment to identify communities in need of treatment, and inform the agreement of a UTG.	• Mapping report • Mapping protocols / diagnostic tools used
LF 3.3	Rapid assessment for Loa loa (RAPLOA) has been conducted where lymphatic filariasis and Loa loa are co-endemic prior to Ivermectin drug treatment, in accordance with Mectizan® expert committee (MEC) guidelines.	• Lymphatic filariasis mapping and RAPLOA maps (ascertain areas of overlap)
LF 3.4	Effectively functioning NTD taskforces / committees exist at different levels.	• Taskforce / committee membership • Meeting reports

LF 3.5	A locally appropriate management information system (MIS) consistent with WHO and NTD formats is in place and supplies necessary and timely information.	• MIS and reports
LF 3.6	Annual treatment with Ivermectin / Diethylcarbamazine and Albendazole is carried out consistent with a GCR of one hundred per cent and TCR of eighty percent as recommended by WHO. In districts where lymphatic filariasis is co endemic with Loa loa (less than twenty per cent), mass drug administration (MDA) is run twice a year with albendazole alone.	• Annual programme report
LF 3.7	Treatment with Ivermectin / Diethylcarbamazine and Albendazole is free to eligible populations in endemic areas.	• Document or policy statement
LF 3.8	A protocol exists and is followed for informing patients of / managing treatment related side-effects and/or serious adverse events in line with MoH and WHO requirements.	• Adverse drug reaction protocol
LF 3.9	Independent post-MDA coverage surveys are undertaken for comparison against reported programme coverage.	• Coverage survey report
LF 3.10	Impact monitoring is conducted to measure reduced prevalence and intensity of infection in treated areas following treatment rounds.	• Impact assessment survey / report
LF 3.11	A transmission assessment survey has been conducted in districts where microfilariae prevalence is less than one per cent to confirm that MDA should be stopped.	• Transmission assessment survey
LF 3.12	Identified population post treatment surveillance needs for lymphatic filariasis elimination are integrated into wider NTD and health / development programmes.	• National strategic plan / NTD Masterplan • Programme plans and reports

Audience	Statement of relevance
Beneficiaries/ Communities	Can expect an effective, integrated and comprehensive programme consistent with WHO recommendations to be in place to eliminate lymphatic filariasis.
Sightsavers Partners	A well planned, adequately resourced, integrated, comprehensive elimination programme that is consistent with WHO recommendations should be in place, with on-going monitoring of key aspects.
Health Professionals	Ensure that professional activities to eliminate lymphatic filariasis are consistent with WHO recommendations, and are effectively delivered, integrated and monitored.

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