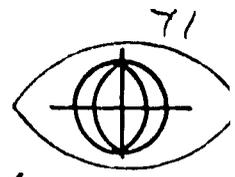


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PD-AAW-401

ISM = 52248

CONTACT:

Robert H. Meaders, M.D.
Medical Director

or

Joseph M. Deering
Executive Director

PROPOSAL FOR PLANNING AND FEASIBILITY STUDY TO DEVELOP
INTEGRATED PRIMARY EYE CARE ACTIVITIES IN
EAST AND SOUTHEAST AFRICA

July, 1980

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PROPOSAL FOR PLANNING AND FEASIBILITY STUDY TO DEVELOP
INTEGRATED PRIMARY EYE CARE ACTIVITIES IN
EAST AND SOUTHEAST AFRICA

GOAL:

To develop strategies for and to assist requesting countries to expand integrated blindness prevention action programs in East and Southeast Africa.

BACKGROUND:

Blindness has been shown to be a major retardant to socio-economic progress in the developing countries of Africa.

Aside from the devastating personal tragedy of blindness in approximately 4% of the mainly rural populations, the loss in productivity of the blind, their continued drain on resources, and the use of the time of a sighted person to care for them creates an intolerable burden on fragile economies.

Fortunately, 75-80% of this blindness has been found to be either preventable or curable using simple, cost-effective measures.

Experience has shown that village health workers doing primary health care can readily be taught primary eye care. Non-medical village workers as well have been trained in primary eye care, becoming capable of identifying and treating eye disease at an early, pre-blinding stage, promoting community public health measures to prevent blindness and referring problems beyond their capability.

Given adequate short term training and on-going supervision, primary eye care workers and non-medical village workers can effectively screen and handle approximately 80% of the patients presenting with eye problems.

A countrywide program integrating primary eye care into primary health care, developing more advanced eye care capability in graduate nurses, and strengthening specialist referral sources has been done in the Kenya Rural Blindness Prevention Project by the IEF under USAID Grant AID/afr-G-1266.

In other countries in East and Southeast Africa, no such programs of this scale exist, or exist as small efforts confined to urban areas where eye specialists are located.

In Bamako, Mali, the IEF sponsored a meeting in collaboration with WHO and partially funded by USAID (Enclosure 1). This meeting used as resource documents the "Guidelines for Programmes for Prevention of Blindness," published as a WHO document in conjunction with the IEF, and a description of the Kenya Rural Blindness Prevention Project. The concept of integrating primary eye care into primary health care training programs was enthusiastically endorsed at this meeting, and recommendation made that efforts be launched to identify, upgrade, and coordinate available or potential national and sub-regional training centers to add the vital primary eye care component to existing or planned primary health care programs.

A further recommendation was that assistance be sought from international, bilateral, and non-governmental sources in

developing logical, clear, concise blindness prevention programs and in identification of resources for implementation.

Previous WHO/IEF collaborative efforts have produced two publications on approaches to blindness prevention programs-- "Guidelines for Programmes for the Prevention of Blindness" and "Proceedings of a Meeting for Definitions of Guidelines for Blindness Prevention Programs in Africa."

Extensive discussions have been held with WHO/Afro in Brazzaville, Congo in June, 1980, where it was mutually agreed to begin collaborative efforts directed towards national and sub-regional primary health care/primary eye care training as well as program development at the request of member nations. Further areas in which valuable resources may be more efficiently utilized are an area agreed upon for collaborative efforts as well.

Definitive steps were undertaken in July, 1980 by IEF and WHO/Afro to hold a sub-regional meeting for seven countries in Malawi in September, 1980 to develop guidelines for prevention of blindness. Thus, initial actions by the IEF can be implemented at this gathering to enlist support of these countries to carry^{OUT} the objectives of this proposal.

PROJECT OBJECTIVES:

1. To examine and document active or potential primary health care/primary eye care training centers where they exist.

2. To investigate the need for and possibility of upgrading or developing primary health care/primary eye care training facilities at both national and sub-regional levels.
3. To investigate means to expand the health manpower pool by stimulating community-based health worker development as primary health care/primary eye care workers.
4. To evaluate available primary health care/primary eye care training curricula and training aids in order to identify areas needing active development.
5. To work with WHO/Afro and other service organizations in developing priorities and methodologies for maximizing utilization of available and potential resources in primary health care and primary eye care training.
6. To work with WHO/Afro and other service and funding agencies to develop a means by which requesting countries may be rendered assistance in evaluation of their needs and resources and in producing a coordinated blindness prevention program integrated into their health care system.
7. To assess means of coordinating program activities in blindness prevention on national and sub-regional levels among donor agencies, governmental, and non-governmental agencies.
8. To develop country-specific prevention of blindness program projects in order to implement intervention and remedial action programs in East and Southeast Africa.

SCOPE OF ACTIVITIES:

Countries to be included in this planning and feasibility study of one year are the following:

Botswana	Sudan
Ethiopia	Swaziland
Kenya	Tanzania
Lesotho	Uganda
Malawi	Zambia
Republic of Somali	Zimbabwe

IMPLEMENTATION:

The IEF has an administrative and professional infrastructure in the Kenya Rural Blindness Prevention Project offices in Nairobi. Cost-sharing of office, secretarial, and administrative support would favor basing this project in Nairobi.

An ophthalmologist experienced in developing country problems, primary health care, and primary eye care would be assigned as Project Director. He would be responsible for accomplishing the Project objectives in conjunction with WHO and national governments.

BUDGET:

Project Director:

Salary	\$ 60,000	
Fringe @ 30%	18,000	
Housing	12,000	
Guard Service	2,400	
RT/EAF (2)	3,800	
Shipping & Storage	<u>4,000</u>	
		\$100,200

Vehicle:

Purchase	Shared Resource	
Maintenance/Insurance	<u>5,000</u>	
		5,000

Support Personnel:

Secretary - Salary	3,600	
Financial Officer	Shared Resource	
Administrative Asst.	<u>Shared Resource</u>	
		3,600

Office Expenses:

Rent (Partially shared)	1,200	
Typewriter	1,500	
Reproduction	1,000	
Supplies	1,000	
Telephone/Telegraph	<u>2,400</u>	
		7,100

Local Costs:

Travel - air & surface	20,000	
Per Diem - 120 days @ average \$55/day	<u>10,000</u>	
		30,000

\$145,900

IEF Administrative Overhead @ 20% 29,180

\$175,080

AFRO-MEMORANDUM

From

CDO *JM*

To

DDC *af*

Date

23 June 1980

Our ref. ICP/PBL/001

Subject: VISIT OF DR TARIZZO AND DR MEADERS TO AFRO IN
CONNECTION WITH MALAWI PEL TRAINING COURSE
21-26 SEPTEMBER 1980

Your ref.

Attached hereto is the record of the discussions held with Dr Tarizzo, Programme Manager PBL/HQ and Dr R. Meaders, Medical Director of the International Eye Foundation (IEF) during their visit on 16 June 1980.

The purpose of their visit was to discuss the form of collaboration of AFRO and IEF in the support of national PBL programmes in the Region. Initially, this collaboration is to be in support of training courses which will lead to the establishment of effective national programmes. IEF will make provision for five countries in the immediate future.

Dr Meaders reported that Malawi has asked IEF for support in organizing a training course from 21-26 September 1980. Fortunately IEF has sufficient funds up to the end of September 1980 for Malawi.

Malawi has indicated her intention to seek the collaboration of AFRO and so in view of the limited time available Dr Meaders wished to know what would be the reaction of the Regional Office to such a request, when it arrives.

If AFRO agrees to support the Malawi training course, IEF will provide the funds for the participation of 5 countries. The Regional Office would be required to invite the participants and arrange their travel. A Regional Officer, CDO or NUT would be expected to support the national organizers. IEF and HQ would provide training material and some trainers.

The Regional Director's decision is required for transmission to Dr Meaders in connection with AFRO collaboration as follows:

- (i) Arrangements for the participation of 5 countries, namely Botswana, Lesotho, Swaziland, Zambia and Zimbabwe.
- (ii) Participation of a Regional Officer in the training course.

Dr Meaders was informed that the Regional Committee takes place 17-24 September 1980.

27 June 1980:

TO: DR. M.L. TARIZZO, PROGRAMME MANAGER PBL?HQ

1. Inform Dr. Meaders that A positive response has been given and further action will be taken with receipt of Malawi request from GOM.

F.C. GRANT

Regional Officer for the Regional Director

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MEETING FOR DEFINITION OF GUIDELINES FOR BLINDNESS
PREVENTION PROGRAMS IN AFRICA
Bamako, Mali - February 24-28, 1980

Report

*Sponsored by the International Eye Foundation in collaboration
with the World Health Organization*

Definition of the Problem

There has been a recent awakening on the part of the governments of many African nations as to the economic and social impact of blindness on their countries' development programs. It has been estimated that the negative impact of visually impaired persons runs in the neighborhood of 4% of the Gross National Product in many countries. Blindness prevalence rates in the developing countries of Africa range from a low of approximately 1.5% to as high as 10% in several of the most severely affected areas. The loss to the community of a productive worker who has become visually disabled is only a portion of the negative impact. In addition to no longer producing, the blinded individual continues to consume. Further, another sighted person must utilize a portion of their productive time in caring for the blinded person. In addition, school training for blinded children is estimated to cost 20 times that of the school costs for non-visually handicapped students. Rehabilitation programs cannot keep up with the constant influx of blind individuals.

Data from surveys done in various countries throughout Africa have shown that approximately 75% of the blindness encountered is either preventable by simple measures or treatable with a reasonable expectation of visual improvement.

The cost to the nation of an effective blindness prevention program is small, indeed, compared to the negative economic and social impact of preventable and/or treatable blindness.

Successful Blindness Prevention Programs Point the Way

There are on the African continent several highly successful, effective blindness prevention programs. In this context, blindness prevention is taken to include both preventive measures and treatment of the curable blind. With the discovery that most of the blinding conditions were either preventable or treatable, there has been a renewed interest in addressing the economic and social dislocation suffered by both the individual and the nation by means of effective blindness prevention programs.

Purpose of the Bamako Meeting

This Meeting was convened for the purpose of developing recommendations suitable for use as guidelines in planning national and regional programs in the prevention of blindness. This Meeting offered an opportunity for ophthalmologists actively engaged in prevention of blindness on the African continent to meet and share past experiences, current needs, and to develop recommendations which will enable them to

implement blindness prevention programs on both a national and regional basis. In order to best utilize scarce resources, the group was asked to consider and make recommendations for regional prevention of blindness cooperative efforts where it was considered practical and feasible. The WHO publication, "Guidelines for Programmes for the Prevention of Blindness," was utilized as a basic working paper with discussions of specific elements by the working groups. The Meeting was a small, informal gathering, and two major topics were addressed. The first was the training of paramedical personnel in the delivery of primary eye care; the second one was strategies for primary eye health care delivery.

Meeting Agenda

On the opening day, a discussion of the general and global problems within the field of prevention of blindness was given by Dr. Mario Tarizzo. Dr. Robert Meaders then gave a brief overview of prevention of blindness programs from the viewpoint of private voluntary organizations working in Africa. Next, Prof. C. O. Quarcoopome, Chairman of the Meeting, addressed the specific tasks to be accomplished, subjects to be discussed, and format of the Meeting. The Minister of Health, Dr. Ngola Traore, formally opened the Meeting with a discussion of the blindness prevention program in Mali and the problems specific to their country. The role of IOTA in the overall countrywide attack on the problems of blindness was outlined.

In the first plenary session, the outlines of three programs were described in detail. The Onchocerciasis Control Program was explained by Dr. Bjorn Thylefors. This was used as an example of a regional program in which several nations with a common problem addressed the treatment of blinding disease in a coordinated, unified fashion. Dr. Feuillerat of IOTA explained the structure and function of the Institut d'Ophtalmologie Tropicale d'Afrique, of which he is the Director. This organization is an example of a facility for training health care workers in the delivery of eye health care both at a national and at a regional level. Dr. Randolph Whitfield, of the International Eye Foundation's Rural Blindness Prevention Program in Kenya, outlined in detail the blindness prevention program as conducted in Kenya. This program, which has been going on for over 25 years, was used as a model for a national blindness prevention program.

Following this, the participants were divided into the two discussion groups and spent the next three sessions in discussing the subject matter and sharing personal experiences both within and related to the assigned subjects of discussion

During one afternoon session, the staff of IOTA provided a tour through the facilities, and a discussion of the structure and function of the Institute followed.

Group recommendations were discussed and further recommendations sought from the opposite group numbers in plenary session. On the last morning, the plenary session discussed

the final summaries of the discussion and recommendations of the two groups. In addition, representatives from the World Health Organization, the Royal Commonwealth Society for the Blind, the International Agency for the Prevention of Blindness, the United States Agency for International Development, and the International Eye Foundation each discussed their own approach to developing, implementing, and funding blindness prevention programs, especially on the African Continent.

The Meeting was closed by a representative of the Ministry of Health. A summary of the Meeting was given by Dr. Robert Meaders and Prof. C. O. Quarcoopome. In addition, closing remarks were given by Dr. Mario Tarizzo, Program Manager of the WHO Prevention of Blindness Programme.

Charge to the Discussion Groups

The participants were divided into two groups. The groups were asked to discuss their particular topics assigned both on the basis of the personal experience gathered in actual operational blindness prevention program management by group participants, "ideal" standards for such a program, and feasibility or desirability of a regionalized approach to such programs. Finally, the groups were asked to develop a set of recommendations for further action and areas which were felt to need further emphasis under the general discussion of guidelines for blindness prevention programs.

Training of Primary Health Care Workers in Eye Health Care Delivery

In this section, discussions were held concerning the appropriate levels of health care workers trained as primary eye health care delivery personnel, appropriate curricula for them, and resources available for national or regional training of eye health care workers. In the group discussions, curricula from various training programs were exchanged between the participants. The training programs at various recognized centers were discussed, and the philosophy of regional training of health care workers from countries with similar patterns of eye disease was approved. The general philosophies as given in the WHO publication, "Guidelines for Programmes for the Prevention of Blindness," were accepted as valid.

During the course of the meeting, there was an exchange of educational material and training aids among participants. This exchange should add to the capabilities of the participants in delivering more meaningful education in primary eye care to health workers.

Recommendations submitted were:

1. Sub-regional training facilities in eye health care should be further developed in different parts of Africa using already existing projects as models for further development.
2. Established and planned teaching centers should be encouraged to develop the capability to handle

regional or sub-regional training in cooperation with other nations having similar patterns of eye disease and linguistic capabilities.

3. An inventory of these already existing teaching programs and their curricula in eye health care should be compiled to guide the future developments along these lines.
4. The National Eye Institute of the National Institutes of Health of the United States of America has volunteered to collect visual teaching aids currently available, including slides, to develop a set of instructional material. The Institute will call upon international experts to help select those slides and visual aids which can be expected to provide the best examples as needed in the teaching curricula of paramedical workers. The initially selected sets of educational material will be field tested and, if needed, modified before a final production set is offered.
5. IOTA has volunteered to translate the Red Eye Chart and Primary Eye Care manual developed by the International Eye Foundation into French and make changes and amendments deemed necessary to fit the local health picture. It is noted that a Spanish language version of these educational materials is already in preparation by the Pan-American Health Organization.

6. In countries having national commitment for integrating eye health care into the general primary health care system, assistance from international, national, and private agencies through multilateral or bilateral agreements should be developed in order to promote these pilot projects.
7. Ophthalmologists and senior paramedical staff in eye health care should be given the opportunity to visit projects in other countries. The experience gained at this meeting and the exchange of ideas and on-the-spot discussion of teaching materials and methodologies available has proven valuable in aiding participants develop practical, effective, and relevant eye health care training programs. Travel fellowships, visiting professor grants, training fellowship grants and sub-regional meetings of this type were recommended as a means to accomplish this objective.

Delivery of Primary Eye Care

Once again, the WHO publication, "Guidelines for Programmes for the Prevention of Blindness," was considered an excellent source of basic information as to methodology for primary eye health care delivery. Emphasis was given to the following topics:

1. It is not necessary to have large numbers of ophthalmologists available to start such a primary eye care program, although such expert help should be sought

initially to design the program and develop a course of instruction for the village level health worker in eye care. Simultaneously, there must be developed a support system for supplying and supervision of the primary eye health care provider. In order to reassure the community that this program is not just an inexpensive way to half-satisfy their eye care needs, a referral system to a more thoroughly trained health care worker must be established.

2. By starting blindness prevention programs in a small, manageable fashion, the communities' expectations will not be raised beyond what can be delivered.
3. In countries with a significant problem concerning infectious eye disease, the development of an effective intervention program should begin in the areas most severely affected with the program being integrated into existing or planned primary health care infrastructures. Village health care workers and others in the far periphery of the primary health care system can be taught in a few sessions those simple techniques necessary for meaningful help. Recognition and treatment of common eye infections, awareness of the need to refer those problems not amenable to local treatment, and means to enlist the community in a preventive campaign are easily added to the capabilities of the village-based health care worker.

Other areas stressed were:

4. Eye health care delivery can be started at the primary health care level without waiting for a complete tertiary

referral center program to be formed. It is to be emphasized that a satisfactory level of primary eye health care can be delivered by paramedical health care workers given suitable instruction and support and supervised regularly. These workers can handle an estimated 30% to 40% of eye problems presenting for treatment.

5. In order to have an effective program of prevention, the educational team must also deliver curative services to persons attending the talks. In the beginning other attractions may be used in order to assure attendance to the health promotion preventive talks such as distributing soap and/or vitamin A pills to attendees.
6. In starting a primary eye care program one must first enlist community support by education as to the need for and benefits derived from a blindness prevention program.

In order to promote the concepts of prevention of blindness and early treatment, public education is vital. Awareness must be raised in individuals and the community by radio, television, periodicals, and group meetings. Visiting teams of specially trained preventive/promotive health workers to explain the conditions adding to the number of avoidably blinded and how the community may address them provides a basis from which the village health worker can begin. It is important that these visiting teams treat persons presenting with eye disease during their discussions to assure continued interested participation by the community.

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It is considered imperative that the community become involved in "owning" this blindness prevention program. This can be done by payment of nominal fees or support of the village health worker by reducing his community work tasks or assisting with his crops. If a village health care delivery program is not in existence, the development of a specific eye health care delivery person at the primary level may well be used to demonstrate the feasibility of further expansion of this level eye health worker into general primary health care.

8. In addition to medical personnel, other forms of eye treatment were discussed as they were used in various countries and proven effective. These included such items as self-treatment by family members after minimal instruction by visiting health workers or after being given instructional pamphlets on clinic visits. Also, teachers in primary schools have been taught to recognize and treat simple eye disease in addition to giving classes as to eye disease and preventive techniques. Pharmacists and shop owners in some areas are given licenses to sell inexpensive antibiotic ointments without prescription. It is necessary, under these circumstances, to educate both the consumer and the provider of the dangers of the use of steroids in the eyes. Tribal leaders in villages or nomadic tribes have, likewise, been given basic education in recognition of eye disease and

simple medications to treat especially infectious eye disease, referring those cases beyond their capability to more expert help.

9. At the level of the secondary eye care facility, added expertise is necessary to provide referral for the first level eye health care worker and more definitive diagnostic and treatment capability. While it would be desirable to have ophthalmologists perform this task, it has been shown feasible to use specially trained personnel from the paramedical field to fulfill this need, including surgery, according to their capability, training, and facilities available.

By training this second level health worker in more advanced (secondary) eye care in addition to their regular medical duties, a significant portion of ocular disease and trauma can be handled in its early, non-blinding state. Those cases beyond the capability of this health worker must be referred to ophthalmic trained physicians for specialized care or, in special cases, to non-physician health care workers with special training in ophthalmology. Careful selection of these secondary level eye care health workers is of great importance. This level of eye care may be delivered either in static facilities or in more costly mobile units, depending upon population grouping, resources available, and needs of the community served. An example of such a program in the International Eye

Foundation Rural Blindness Prevention Program in Kenya was discussed in detail by Dr: Whitfield.

10. In integrating primary eye care into primary health care, it was agreed that initial program development should be in areas identified as having the greatest need. It was considered appropriate to begin the programs small with a manageable, effective outline for a pilot project. The experience obtained from this may be used to guide development of further programs.
11. The limits of the eye health care workers' capabilities should be guided by the needs, resources, and training available. In addition, all members of the health care team, including drivers, sweepers, and so forth, in addition to paramedics should have appropriate training in eye health care as they are frequently approached by patients for advice.
12. Medical school curricula in ophthalmology should be relevant and appropriate to the needs of the country and made suitable for the graduate student to utilize in delivery of eye care and supervision of primary eye care delivery by paramedics. In addition, it was recommended that undergraduate medical students spend some time in peripheral health units to observe first-hand both general and ocular primary health care.

Plenary Session Discussions of Working Groups' Recommendations

1. Regional Assessment Programs - A group discussion was held as to the feasibility of survey results from one country being extrapolated for a geographically, culturally, socially, and economically similar second country. It was agreed that this could only be a general guideline for developing an assessment scheme within the second country owing to the lack of true uniformity in disease patterns across any of the above lines. While such baseline information may be used to initiate a primary eye care program, more detailed information is necessary in order to detect foci of high prevalence of eye disease and blindness. It was also stressed that utilization of information obtained in assessment programs must include an assessment of resources available in order to make a meaningful interposition of eye care into existing or planned primary health care systems.
2. Regional Treatment Programs - Under the concept of regionalized treatment programs, it was agreed that the principal ocular disease amenable to the regional concept of control was that of onchocerciasis. Variability in health delivery infrastructures and disease patterns make cooperative efforts very difficult. The group discussed and recommended promoting of regional cooperation between developing countries but emphasized that countries should build their own blindness prevention programs from identified

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needs and resources. While an exchange of ideas, methodology, and training can be done regionally, actual health care delivery usually stops at national borders for many valid reasons.

3. Focusing National Will - Questions were asked as to the actual mechanism to stimulate national will to initiate a blindness prevention program. In group discussions, it was stressed that people and not pamphlets were the most important ingredient. There must be a strong commitment on the part of both the professional and lay community to influence the political structure of the country to act. Social action groups such as Lions Clubs and Rotary International, influential social, political, and economic leaders can be utilized to focus public attention on the necessity of a blindness prevention program.

A strong central blindness prevention committee should be formed in order to centralize and coordinate efforts of various groups in developing, implementing, and refining blindness prevention programs in conjunction with the Ministry of Health.

At times the ophthalmic community can focus national attention via such striking methods as the publicity surrounding the starting of an eye bank or well publicizing meetings of blindness prevention societies within the country.

4. Program Development - In the early phase of blindness prevention program development, assistance should be sought from proven resource agencies. A list of such sources of assistance and their specific fields of expertise is being made available by the WHO/IAPB.

At this point, various governmental and non-governmental agencies represented at the Meeting discussed their role in program development. Prof. Barrie Jones of England, representing both the Royal Commonwealth Society for the Blind and the International Agency for the Prevention of Blindness, discussed the ways in which both agencies assisted countries to develop and implement blindness prevention programs. Dr. Mario Tarizzo, Program Manager of the WHO Prevention of Blindness Programme, discussed the structure and function of that particular program and the means by which WHO can assist countries in developing programs for blindness prevention. Mr. Joseph Deering explained the role of the IEF in assisting countries in developing and implementing blindness prevention programs.

5. Program Funding - As the success of any program depends also upon adequate funding, it was stressed that the government must commit at least a portion of its health care resources to blindness prevention. In order to broaden the reach of these programs, other sources of funding were discussed. Common to the application

procedure was; the need for the presentation of a simple, practical, well-defined program to the funding agencies.

Representatives of WHO, IAPB, Royal Commonwealth Society for the Blind, USAID, and the International Eye Foundation discussed their particular roles in assisting countries to marshal available resources and seek funding from both governmental and non-governmental sources for program implementation.

Distribution of Meeting Report

It was recommended that the final draft report of this Meeting be distributed to at least the Ministers of Health and their Chief Ophthalmic Advisors throughout all African countries to emphasize the importance prevention of blindness plays in the overall health care and to lend assistance to those dedicated people working to relieve the unnecessary burden of avoidable blindness.

Need For Further Meetings

It was recommended that further meetings of this type be held. The meetings should be small, informal, and allow representatives of the Ministries of Health and ophthalmic communities of attending countries to interface directly with their counterparts in countries with similar patterns of disease and of similar linguistic capability.

It was also thought appropriate that representatives of agencies capable of assisting in program development,

implementation, and funding assistance attend these meetings. Where possible, managers or directors of on-going, recognized blindness prevention programs should be invited guests in order that they might share their experiences in formulating, operating, and refining their programs.

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