THEME SYMPOSIUM

Basis of the Global Eye Health Action Plan: Universal Eye Health 2014-19

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In May 2009 the World Health Assembly (WHA) in Geneva, adopted resolution WHA 62.1 endorsing 'The Action plan for avoidable blindness 2009–2013'. The resolution urged member states to implement the action plan for blindness and visual impairment according to national priorities. In May 2012 considering the plan will expire in 2013 the WHA in Geneva, approved the development of a new Action plan 2014–19 that will build on the gains of the previous plan. As a result in May 2013 at its 66th WHA, the World Health Organization (WHO) adopted resolution WHA 66.4 which approved a new Global action plan 'Universal Eye Health 2014–19'. The resolution request countries to strengthen national efforts to prevent avoidable visual impairment including blindness through integration of eye health into national health plans and delivery, also to implement the actions in the global action plan 2014–19 according to national priorities.

The priorities of the new action plan were shaped by the global health priorities in the last decade. These included United Nations millennium summit of the year 2000 that endorsed the millennium development goals (MDG). The MDGs meant that eye health needed inclusiveness and leveraging on activities of other sectors. In 2006 the United Nations convention on the rights of people living with disabilities demonstrated that eye health needs to be pursued within the fora of all disabilities with inclusiveness of care. The WHO World health report of 2012 further signified relevance of addressing disability including blindness in a wholesome approach. The neglected tropical diseases control momentum of 2006 rekindled the hope of eliminating trachoma and onchocerciasis as diseases of public health significance. While in 2008 Primary health care (PHC) became a global health priority once again as it formed the years WHO health report. This resurfaced the need to integrate primary eye care into PHC. By 2010 the WHO Health system blocks assumed significance as a holistic approach to assess and manage health care. Its application in eye heath care was seen as a way to integrate eye health within the general health structure. Then came the global attention on the increasing rise in non-communicable diseases in this decade resulting in a special UN high level meeting of the General assembly which adopted a special resolution to prevent and control non-communicable diseases. Many of the emerging causes of visual impairment are chronic aging diseases sharing similar risk factors to some NCDs. So their control will need linkages with NCD control programs.

Thus the foregoing formed the basis of the new global eye health plan. They can be summarized into the following themes: Evidence based approach to health care, Comprehensiveness and inclusiveness in health care e.g. NCD/NTD/Disability, Integration of health intervention through existing health structure, Building interventions on the 6 WHO Health system blocks, Building health care upon PHC and pursuit of health care through multi-sectoral linkages/collaboration with development groups.

It is upon this that the new global action plan: Universal eye health 2014–19 has the following goals and objectives.

Goal: To reduce avoidable visual impairment and secure access to rehabilitation services for those visually impaired

Purpose: To improve access to comprehensive eye care services integrated in health systems

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Objectives	Activities
Objective 1 Evidence generated and used to advocate for increased political and financial commitment of WHO Member States for eye health	Undertake population-based surveys on prevalence of visual impairment and its causes Assess the capacity of member states to provide comprehensive eye care services and identify gaps Document, and use for advocacy, examples of best practice in enhancing universal access to eye care
Objective 2 National policies, plans and programmes for eye health which are integrated into national health systems developed, strengthened and implemented	Provide leadership and governance for eye health Secure adequate financial resources to improve eye health and comprehensive eye care services integrated into health systems Develop and maintain a sustainable workforce as part of the broader human resources for health workforce Make available and accessible essential medicines, diagnostics and health technologies Include indicators for the monitoring of provision and quality of eye care services in national information systems
Objective 3 Multi-sectoral engagement and effective partnerships for improved eye health strengthened	Engage non-health sectors in developing and implementing eye health Enhance effective international and national partnerships and alliances Integrate eye health into poverty-reduction strategies, initiatives and wider socioeconomic policies

WHO: World Health Organization

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Developing Comprehensive Eye Care Services in Nigeria: Sightsavers Experience

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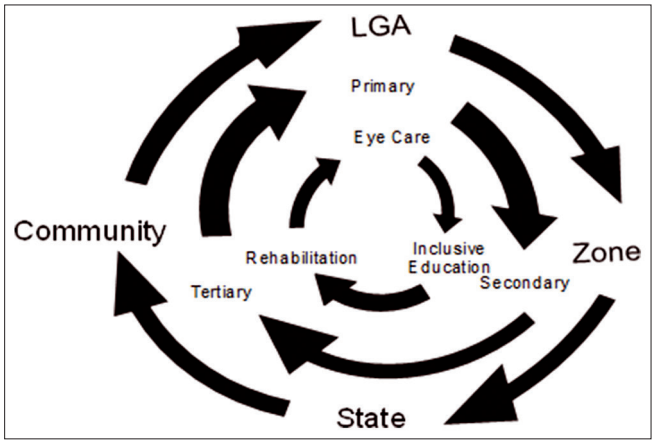
Comprehensive eye care services (CES) includes eye health promotion, prevention, diagnosis and treatment of all relevant eye diseases; rehabilitation of those with irreversible blindness and education of blind and visually impaired children. CES aims at eliminating avoidable blindness in communities, where participation self-mobilization for eye health services is fundamental.[1] Sightsavers approach in Nigeria is based on developing state wide CES using a methodological approach with clear objectives and expected outcomes. This involves situation analysis of the exiting eye care services and eye conditions, developing human resources and setting up equitably distributed teams for service delivery across the state within the existing health system and linkages to rehabilitation and education. All stakeholders including community representatives are involved and agree roles and responsibilities including systems and structures for program implementation. Program management, technical and advocacy/resource mobilization teams were set up ensure successful program implementation.[2] Delivery was patients focus towards ensuring accessibility, availability and affordability of quality services. Coverage was centered on meeting the needs of the population, being part of and strengthening health systems and disease focus-cataract, trachoma, childhood blindness, low vision and refractive error services, rehabilitation and education.[2] Eye health providers have clear roles and responsibilities and delegate responsibilities for multiplier effect. They were motivated to ensure that services are organized based on population needs and coordination of activities and efficient use of personnel.[3] Linkages in CES are established between services-eye care, rehabilitation, education, water supply and sanitation and between levels-state, zone, LGA, community.[3] Comprehensive eye care services is based on six building blocks of CES that deliver effective, safe, high-quality interventions; reorientation of the eye health workforce towards more long-term care and support with the necessary skills and knowledge for a patient-centered approach; an eye health information system, which ensures captures, analyze and disseminates reliable and timely information on eye health determinants and health system performance; equitable access to essential medical products and technologies of assured quality, safety, efficacy and cost effectiveness; an eye health financing system, which ensures adequate funds for sustainable eye health; leadership and governance to strengthen existing national/state eye health policies and plan as part of wider health systems with linkages to social services (rehabilitation and education).[1] The successful implementation of CES in five states in Nigeria has led to increased service delivery in high volume surgery centers, good quality outcomes and better patient satisfaction, skilled and motivated eye care providers working as teams, better equipped facilities and linkages between tertiary and secondary facilities and the primary health care system and success in achieving Vision 2020 targets and better linkages between health, rehabilitation and education.[3] To sustain these, government needs to prioritize eye health and improve funding of eye health activities/services; partnership/collaboration by various stakeholders is very important for linkages and ownership of programs by communities.[3]



Comprehensive eye care linkages

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Integrating Eye Health into National Health System (NIGERIA)

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Eye care interventions in developing countries have generally been vertically implemented (e.g. trachoma control, cataract surgeries) often with parallel organizational structures or specialized disease services.[1] Eye care service, in addition has been established as an entity, existing as eye hospitals and eye clinics outside the rest of the health care structure.[2] However, Vision 2020 strategy has extensively promoted the integration of eye care services into the national health system with the aim of elimination of avoidable blindness by the year 2020. Integration of eye health into the national health system remains the cornerstone of initiatives to revitalize Primary Health Care.[3] Integration of eye care involves ways in which Eye care staff can engage with the wider health system, identify ways to interact with their peers, influence decision makers, and advocate for change.[3] In advocating integration of eye health into the national health system, an understanding of eye health, health system and integration is necessary. Eye health is the complete well-being of the organ of sight and the visual system and not merely the absence of disease. Integration defined by WHO 'is the management and delivery of health service so that clients receive a continuum of preventive and curative services according to their needs over time and across different levels of health system'.[3] World Health Organization has defined health system as 'all organizations, people and actions whose intent is to promote, restore or maintain health'.[3] Every country has its unique health system, Nigeria inclusive. The foundations of a health system according to Islam and WHO[4,5] comprise six components namely: governance, service delivery, financing, human resources, health technology and equipment and supplies. Eye health can and should be integrated within all the six components of the health system of Federal, State and Local government levels of Nigeria.

- Governance – formation of eye health policy, inclusion of eye health into National Health Insurance Scheme, introduction of incentives to deploy eye health staff to remote areas and exemption of user fees for the elderly and poor.
- Service delivery – decentralization of services, decisions of budgeting, planning and allocation of eye resources should be done at all the level of three tiers of Nigerian government.

1. Integration of eye care into general health system where all mechanism in the general health system are applied to eye health such as patient records, budgeting and patient circuit.

2. Strengthening of outreach eye activities with the help of community eye care workers thus bringing eye services closer to the population.

Promotion of preventive eye health activities such as Vitamin A distribution, measles immunization, facial and environmental hygiene, etc.

- Financing – budgeting in every level of eye health care system (primary, secondary, tertiary). Estimating cost of annual action plan and incorporating in the general budget.
- Human resources – training of eye care professionals; supervision of eye care staff, recruitment and training general practitioners in Primary Eye Care and involving traditional healers, traditional birth attendants, school teachers and community members in eye care activities.
- Health technology, Equipment and Supplies – provision of appropriate infrastructure, equipment, equipment maintenance, supplies, effective supply chain is required for eye care personnel to function effectively.
- Comprehensive ophthalmic medications should be on the National essential drug package.

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Meeting Eyecare Needs in Nigeria through Eye Camps: The Need for Guidelines

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Abstract: Efforts to reduce the prevalence of cataract blindness in Nigeria have led to the proliferation of cataract surgical eye camps. There is a need for these activities cost-effective and beneficial to the cataract patient to justify the practice. This requires the establishment of minimum standards for the operation of eye camps. The Ophthalmological Society of Nigeria fulfills this need by setting guidelines for eye camps in Nigeria.

Keywords: Cataract, eye camp, guideline, Nigeria

Introduction: Eye diseases and blindness are of public health concern in Nigeria. The Nigeria National blindness survey reported 4.2% blindness prevalence among Nigerian adults aged 40 years and above.[1] Cataract constituted nearly 50% of the cases of blindness. In terms of numbers, the national survey estimated that in 2007, 1 million Nigerian adults were blind; another 3 million had low vision, and 500,000 needed cataract surgery. Surgery is for now the confident method of reversing cataract blindness. However, previous studies suggested low cataract surgical rate as well as low cataract surgical coverage especially for rural dwellers in Nigeria.[2] In an effort to clear the cataract backlog and thus reduce blindness prevalence, community outreaches and cataract surgical eye camps often sponsored by eye health workers, philanthropists, faith-based organizations, Non-governmental Organizations, politicians, government, etc., have been embarked upon in different parts of Nigeria. This exercise has become so popular that some politicians have used it as a vote-catching tool. From the time to time, foreign eye health workers are brought into Nigeria by some politicians and government officials to conduct cataract surgical eye camps without involving the local eye health workers. The bane of such an otherwise useful program is the lack of adequate follow-up. Inadequate postoperative care often turns an otherwise excellent surgery into a nightmare and prolonged sorrow for the patient. Clear guidelines are necessary in order to protect the public, maintain standards of care and ensure good results from eye camps. The Ophthalmological Society of Nigeria (OSN) in its strategic plan had formulated presented minimum standards to guide eye camp organizers.[3] Recent advances in knowledge and technology have necessitated the revision and updating of the guidelines, viz.:

Manpower

1. Every eye camp team must have local ophthalmologist as part of the team.
2. The local ophthalmologist must
   - Have a valid/current practicing license.
   - Accept responsibility for the conduct of the camp.
   - Ensure professional standard of practice.
3. Any visiting ophthalmologist in the team must be duly registered with the Nigerian Medical and Dental Council of Nigeria.
4. Foreign ophthalmologists must accept to work with the Nigerian ophthalmologists.

Sponsors

1. Sponsorship is open.
2. When sponsorship is by a local philanthropy group (religious, corporate, political or individuals), the State Coordinator of Blindness Prevention Programme should be notified and should be actively involved in the planning as well as execution of the camp.
3. Where there are no ophthalmologists in a particular State, the ophthalmologists in the neighboring State(s) should be co-opted to be part of the team in an active manner.

Team leader

The team leader must ensure that:

- Individuals involved with the eye camp have the relevant qualification and experience.
- Members of the team are appropriately registered with the Nigerian Council.
- Good collaboration exists between the visiting team and the local participants.
- Good ethical practice is maintained in the camp.
- Relevant standards of instrument and sterilization methods, as well as infection control, are in place.
- Adequate preparation made for resuscitation (materials, manpower and facilities). This includes skilled personnel to resuscitate, adequate equipment and drug to effect, bed space within a reasonable distance to manage such patients as well as a stand-by ambulance to convey such patients, if need be, to a hospital that can adequately manage them.
- Adequate documented arrangement is made with hospital(s) and personnel within a reasonable distance to manage surgical complications (e.g. vitreo-retinal surgeon to manage nucleus drop).
- Adequate documented arrangement put in place for follow-up for routine visits as well as for postoperative complications after the departure of the visiting team
- That follow-up hospitals or clinics and eye physicians are designated and known to all before the commencement of the camp.
- That immediate postoperative consumables and drugs are made available for all patients for the expected duration of recuperation (for extra-capsular cataract extraction/small incision cataract surgery [ECCE/SICS] not <4 weeks). Where patients have to pay, the cost estimate must be clearly stated and known to all patients before surgery is performed.

Screening

1. Examine the eye(s) to establish that cataract is the only or most significant cause of visual impairment and that cataract surgery would significantly improve vision.
2. Exclude or identify other ocular or systemic conditions that might contribute to the patient's visual impairment, or affect patient's general well-being and intervene by referral for appropriate care.
3. Exclude or identify any condition that may affect surgical plan

and ultimate goal and treat the condition. Such patient should be referred for further care and adequate preparation for surgery at a tertiary eye hospital.

4. The document should reflect the status of both eyes and include the following components:
   - Good medical history.
   - Past ocular history.
   - Visual acuity unaided and aided (glasses or pinhole), light projection in 4 quadrants.
   - Intraocular pressure measurement.
   - Pupillary light reactions.
   - Extra-ocular muscle motility.
   - Slit lamp examination.
   - Dilated fundus examination.
   - Biometry (keratometry and A-Scan [for axial length]).
5. The patients should be re-assessed shortly before surgery in cases that had been screened weeks before surgery to avoid missing recently developed pathologies.

Surgical technique

1. The gold standard technique for cataract surgery is Phacoemulsification with appropriate foldable intraocular lens (IOL) implant
2. The preferred surgical procedure is manual SICS with appropriate IOL implant.
3. The minimum acceptable surgical procedure is with appropriate IOL implant (ECCE/IOL)
4. Surgery without an IOL implant is not acceptable, except when it is inimical to the health of the eye
5. Biometry must be done so as to have a predictable visual outcome
6. Only one eye of a patient should be operated upon at a camp
7. A patient with only one functional eye (precious or only eye) should not be operated upon in an eye camp setting in the absence of an experienced and proficient surgeon

Contraindications

Surgery should not be performed if the patient:

- Does not consent to surgery.
- Is a child.
- Is medically unfit.
- Unable to maintain adequate postoperative care.
- Needs special variant of surgery involving special equipment.
- Has systemic sepsis or infected wounds on the face or anywhere in the body.

Documentation

1. Each surgical site and each surgeon must record their surgical procedures using the cataract surgical operation form (*catops*).
2. A computer and a soft copy of the form is used to facilitate easy and onsite analysis.
3. This defines the surgical outcome and the success of the cataract camp.

Monitoring/evaluation

1. The monitoring of the eye camp activities is the primary responsibility of the camp organizers and the leadership of the OSN chapter in the state. A completion of eye camp activity report should be sent to the State Blindness Prevention Committee. The committee should inform the Zonal Coordinators of OSN covering the State where the Camp is taking place. OSN members should also be monitoring such activities in their State and can directly inform the OSN Zonal Coordinator.
2. Statistical data to be submitted include:
   (a) General eye camp report (which reports on the team, planning, flow of patients, demography, diagnosis seen, etc.)
   (b) Report of the analysis of the cataract operation. This will define the surgical outcome and percentage as well as describe the complications encountered.
3. These should also be forwarded to the State Ministry of Health, the OSN Zonal Coordinators and the National Coordinator, Blindness Prevention Programme, Federal Ministry of Health, Abuja.

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