SEA-Opthal-118
Distribution: General

Vision 2020: The Right to Sight

Report of an Intercountry Consultation on Development of Regional Strategies
Jakarta, 14- 17 February 2000

WHO Project: ICP OSD 002

World Health Organization
Regional Office for South-East Asia
New Delhi
January 2001

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1. INTRODUCTION

An Intercountry Consultation for the Development of Regional Strategies for Vision 2020: the Right to Sight was convened in Jakarta, Indonesia from 14 –17 February 2000. Twenty-one participants from nine member countries and eight representatives of International Nongovernmental Development Organizations (INGDOs) and World Health Organization (WHO) Secretariat from Headquarters, South East-Asia Regional Office and Country Office participated in the meeting. (List of Participants is at Annex 1)

2. OBJECTIVES AND EXPECTED OUTCOME

2.1 Objectives

(1) To review the current status of blindness and visual impairment and progress in implementation of country activities in Member Countries;

(2) To orient the participants on Global Initiative for Elimination of Avoidable Blindness Vision 2020. The Right to Sight;

(3) To formulate a regional strategy and plan of action for Vision 2020, and

(4) To develop a template for designing/redesigning national plans of action to meet the objectives of Vision 2020, and work out a time frame for national launches of Vision 2020.

2.2 Expected outcome

(1) A document outlining current status of visual health, blindness and visual impairment, resources and infrastructure availability in the Region. This document (based on country reports) will constitute the basis for future monitoring and evaluation.

(2) A document outlining 20 years ' strategic plan for Vision 2020, with targets, indicators and cost (regional version of Vision 2020).

(3) A technical plan of action for 2000 –2004.

(4) A detailed plan of action for 2000 - 2001 with identification of projects for implementation in the first two years.

(5) A template and time-frame for development of national policies, programmes and plan of action.

(6) A tentative schedule for launching of vision 2020 in the countries.

3. INAUGURATION

The Director-General of Community Health, Indonesia and the Regional Director, WHO South-East Asia Region jointly opened the Consultation. In his welcome address, Dr. Uton Muchtar Rafei, Regional Director, WHO South-East Asia Region, stressed the magnitude of the problem of avoidable blindness in the Region and its far-reaching implications in developmental, socio-economic and quality of life terms. He referred to the rapidly increasing burden of needless blindness as a consequence of rapid population growth as well as the disproportionate growth of the elderly population. He emphasized the need for concerted action and reiterated the commitment of the World Health Organization toward(s) this cause. Welcoming the representatives of the INGDOs to the consultation, he said their participation would greatly complement the activities taking place in countries presently supported by national governments.

In his inaugural address, Professor Dr. Azrul Azwar, Director-General, Community Health, Ministry of Health, Indonesia thanked WHO for choosing Indonesia as the venue for the meeting, as this together with the ceremonial launching of "Indonesia Vision 2020" by Her Excellency the Vice-President, would focus attention on the overwhelming burden of avoidable blindness in Indonesia. He acknowledged that due to competing demands, the eye care programme has not been considered a priority and assured that it will be accorded greater priority in future planning. However, despite considerable inputs into prevention of blindness activities, progress has been slow. He was confident that this Consultation would provide an opportunity for sharing of information and experiences between countries.

Chairperson, Vice-Chairperson and Rapporteur : Dr. Rachmi Ontoro (Indonesia) and Dr. Rachel Jose(India) were nominated as Chairperson and

Vice-Chairperson respectively. Dr. Kunzang Getshen (Bhutan) served as Rapporteur.

Launching of Vision 2020 Indonesia: Indonesia VISION 2020 was ceremonially launched by Her Excellency Ibu Megawati Soekarnoputri, Vice President, Republic of Indonesia on 15 February 2000, at the Vice Presidential Palace, Jakarta.

Process: The programme of the Consultation is at Annex 2. Nine countries of the Region (except for DPRK) presented their country reports. A summary of the country status is presented in Table 1. INGOS working in the Region described their activities. A summary of these is presented in Table 2.

Introductory presentations were made by WHO staff briefed the participants about the global and regional implementation of blindness scenario as well as progress of implementation of Vision 2020: the Right to Sight.

Group work: Participants worked in groups to define Mission for Regional Eye Health, Objectives of Vision 2020: The Right to Sight in SEAR and key strategies to achieve these. The details of these have been issued as SEA-Ophthal-117 Strategic Plan for Vision 2020: the Right to Sight.

4. VISUAL STATUS IN SEAR COUNTRIES

Profile of Blindness in South-East Asia
25% of world's population
33% of world's blind
40% of world's poor
50% of world's childhood blindness
60% of world's cataract backlog
Highest number of blind persons among WHO Regions

Table 1

Eye Health Status in SEAR

	Prevalence of Blindness Percentage						Number of Ophthal-mologists			National PBL Prog. Comm.	
Bangladesh	1	1300000	Cataract, Refr. Error, Corneal blindness, Childhood blindness	738816	500	30	500	?			
Bhutan	0.8	5600	Cataract Refr. error, childhood blindness, Trauma	3777	1019	100	3	15	?	?	+
DPR Korea	NA		NA	NA	NA	NA	NA	NA	?	?	?
India	0.7	6800000	Cataract, Refr.error, Childhood blindness, Corneal blindness	6546053	3400	34	11000	6000	24670	+	+
Indonesia	1.5	2948761	Cataract, Childhood Blindness, Refr.error	1562843	350	20	500	2200	615	+	+
Maldives	0.8	1959	Cataract, Refr.error, Corneal blindness	1254	700	35	3	4		?	?
Myanmar	0.9	427617	Cataract, Trachoma Refractive error, angle clos. Glaucoma	273675	500	50	125	160	1270	+	+
Nepal	0.8	325918	Cataract, Trachoma Refr. Error, Childhood blindness	1291508	900	85	82	204	1096	+	+
Sri Lanka	0.5	92920	Cataract, Refractive error, glaucoma.	64579	1337	100	35	59	?	+	+
Thailand	0.3	242341	Cataract, Glaucoma Refr. error, age related mac. degn.	136296	1667	90	556	320	2200	+	+

Table 2
Summary of INGO s Activities

									Total Disburse-ment in SEAR (1999)	
SSI	Haywards Heath London,UK	Ind, Ban Tha	Policy, Cataract		Mass Cataract Surgery	UK Charity				
HKI	NY,NY, USA	Ino, Nep Ban	Policy, Xero-phalmia Primary eye care		Vitamin A deficiency					
ORBIS	NY,NY, USA	Ind, Ban	Policy training Childhood blindness		Technology transfer Training					
SEVA	Berkley, CA, USA	Ind, Nep	Policy, Management Infrastructure		Programme development			Lumbini Eye Care Project in Nepal Arvind in India		Cataract Childhood blindness Trachoma
CBM	Bensheim Germany	Ind,,Ban Nep, Ino MMR	Infrastructure Cataract Rehabilitation		Infrastructure, cataract, low cost spectacles and eye drops	Voluntary donation in Germany & 10 Western countries	Mutual consul-tation	281		
Lions Sight first	Oak Brook USA	Ind, Ino Nep Srl, Tha	Infrastructure Cataract Management		Infrastructure Cataract Management					
Operation Eyesight Universal	Calgary, Canada	Ind, Nep	Infrastructure Training		Training, Infrastructure					
ICEE	Sydney, Australia	Ind	Refr. Error, Low vision, Training		Operation Research Training Advocacy					
Fred Hollows Foundation	Sydney Australia	Nep, Tha	IOL produc-tion Cataract Surgery							

SSI = Sight Savers International; HKI = Helen Keller International; CBM = Christoffel Blinden Mission; ICEE = International Centre for Eye Care Education

Prevalence of blindness

The prevalence of blindness in the Region is around 0.8%. The rates vary from 0.3% for Thailand to 1.5% for Indonesia. The blindness prevalence rate for Thailand is comparable to developed countries and is a reflection of the outstanding achievement of the Thai national programme for prevention of blindness. The highest blindness prevalence rate of 1.5% reported from Indonesia is comparable to Sub-Saharan Africa.

Comparison between countries is difficult in view of the different methods adopted for data collection. While some are population-based data, others are based on data from different sources. Serial surveys have been conducted in India and Thailand. Even when periodic surveys have been done, methodologies adopted have come under criticism from different sources.

Notwithstanding the methodological differences, the South-East Asia Region of the WHO has close to 15 million of the world's 45 million blind, a disproportionately high burden of one-third of world's blindness for one quarter of the globe's population. South East Asia Region also has half of the world's 1.5 million blind children.

The prevalence of blindness varies not only between the countries but also within the countries. In all countries of the Region, prevalence of blindness is higher among women. Elderly, the rural poor and the marginalized suffer more often.

Causes of blindness

Cataract is the single most common cause of blindness in the countries of the Region. Its contribution varying from 50 to 75%. Uncorrected refractive errors are being increasingly recognized as cause of blindness and low vision. Trachoma is rapidly declining but still remains as important cause of blindness in pockets in India, Myanmar and Nepal. Vitamin A deficiency, which has been responsible for most of childhood blindness in the Region, is gradually declining. The emerging causes of blindness include glaucoma, age-related macular degeneration, diabetic retinopathy, corneal ulcer and ocular trauma.

Cataract backlog

There is an unoperated cataract backlog of about 10-12 million. Cataract surgical rate varies from a low 350/million population per year in Indonesia to 3400/million population per year in India. Intraocular lens implementation rates are increasing and vary from a low 20% in Indonesia to close to 100% in Bhutan and Sri Lanka. Visual outcome of cataract surgery is still poor in one-third of the operated cases. The poor outcome of surgery is often a barrier to uptake of surgery by prospective clients. It is recognized that quality outcome of surgery will go a long way in increasing the number of cataract surgeries.

Ophthalmologists

Except for India and Thailand, there is in general a shortage of ophthalmologist in the countries of the Region. Their numbers will need to be rapidly increased. Ophthalmologists are concentrated in urban areas leaving behind the rural poor grossly underserved.

Middle level eye care workers

The total number of middle level eye care workers is far below the required number. This category of eye care workers such as optometrists, opticians, ophthalmic nurses, ophthalmic assistants and nurse practitioners needs to be rapidly increased. A review of the successful national programmes reveals that they are based on efficient and effective utilization mid-level workers in field teams.

Primary eye care and community eye health workers

Many countries have successfully integrated primary eye care into primary health care by training PHC workers in eye care and supporting PHC infrastructure. Some countries have trained community workers and school teachers with successful outcome.

National programmes, coordination committees and national focal persons

National committees for prevention of blindness exist in most countries. In many countries, they need to be revamped while in others, they have to be

reorganized in order to take key stakeholders on board. Such committees need to be broad-based for the partnership to function to the advantage of all concerned.

Many countries have their annual and five-year plans for PBL. A long-term Strategic Plan for 20 years, intermediate term and short term plan of action need to be drawn-up in most countries.

National focal points have been identified in some countries. Frequent changes of national focal points in some countries and lack of identification in other countries are a source of concern.

5. Key Recommendations

5.1 To the Countries

Advocacy

To promote advocacy, it was recommended that countries:

(1) Launch National Vision 2020 in consultation with national authorities and WHO;

(2) Develop National Plan of Action and identify national focal points;

(3) Observe World Sight Day on the second Tuesday of October every year, and

(4) Develop advocacy materials.

Disease Burden

(1) In addition to the priority given to cataract in most national programmes, attention should be paid to provision of comprehensive eye care including refractive services and low vision services as well as childhood blindness; and

(2) Measures to monitor the outcome of cataract surgery and ensure quality outcome should be instituted as a key strategy to increase surgical output.

Human resources for health

(1) The utilization of available resources should be optimized after identifying barriers, through a multi-country study;

(2) Immediate steps should be taken to increase the number of mid-level eye care workers;

(3) Surgical training in cataract surgery should be provided to selected medical practitioners for urgent clearing of cataract backlog as an interim measure in countries with few ophthalmologists and huge cataract backlog, and

(4) Efforts should be intensified to train PHC workers in primary eye care for speedy integration of eye care into primary health care.

Management

Countries should identify national focal persons, constitute national coordinating body, develop national plan of action and secure WHO assistance in training selected personnel for efficient and effective management of eye care programme.

5.2 To WHO/SEARO

(1) Establish a regional programme unit and a post of Regional Adviser for PBD;

(2) Constitute a Regional Coordination Group;

(3) Allocate necessary resources at global and regional levels;

(4) Assist countries in developing national plans of action;

(5) Assist countries in training eye care programme managers, and

(6) Develop a multi-country study to identify barriers to optimal utilization of resources in selected countries to enhance capacity-building.

Annex 1

LIST OF PARTICIPANTS

SEAR Countries

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Annex 2

PROGRAMME

Monday, 14 February 2000

0900 –1030 hrs	Inaugural Ceremony, Launching Vision 2020, Indonesia and Press Conference.
1100 –1230 hrs	Technical session I:Current status
	a. Global blindness scenario - *S Resnikoff*
	b. Progress in Regional Blindness programme - *S Ramaboot*
	c. Vision 2020:Right to Sight - *R Pararajasegaram*
	d. SEARO response to vision 2020 –*M Upadhyay*
1400 –1530 hrs	Country Presentation (Six countries) BAN/BHU/DPRK/IND/INO/MAV
1600 –1700 hrs	Country presentation (4 countries), MMR/NEP/SRL/THA
1700 –1730 hrs	Discussion

Tuesday, 15 February 2000

0830 –0930 hrs	Presentations by IAPB /INGOs
1000 –1230 hrs	**Group work**
	Technical session II: Objectives Mission and Targets
	a. Objectives and Mission
	b. Targets for reducing disease burden
	c. Targets for HRH
	d. Targets for infrastructure and technology

1400 – 1530 hrs	Presentation by the groups
1545 – 1700 hrs	Group discussion continues (Finalize targets)

Wednesday, 16 February 2000

0830 – 1030 hrs	Technical Session III: Strategies and Plan of Action. a. Strategies and PoA for reducing disease burden b. Strategies and PoA for HRH C Strategies and PoA for Infrastructure and c. Technology development
1100 – 1230 hrs	Group Presentations
1400 – 1530 hrs	Technical Session IV: Indicators for monitoring and evaluation a. Indicators for reducing disease burden Indicators for human resources b. Indicators for infrastructure and technology
1600 – 1700 hrs	Presentation of group work

Thursday, 17 February 2000

0830 – 1000 hrs	**Group Work** Technical Session V: Resources a. Resources needed for reducing burden of disease b. Resources needed for HRH development c. Resources needed for infrastructure and Technology development
1030 – 1130 hrs	Discussion on Resources
1130 – 1230 hrs	Detailed PoA for 2000-2001 – Discussion
1400 – 1500 hrs	Template and time-frame for formulation of national policies, programmes and plan of Action. Recommendations and Closing