



# Implementation of the Action Plan for the Prevention of Avoidable Blindness and Visual Impairment

**A Regional Workshop for the South East Asia Region**  
September 22-24, 2011

***Organized by:***

*laico*  
LIONS ARAVIND INSTITUTE OF  
COMMUNITY OPHTHALMOLOGY

***Supported by:***



The **Fred Hollows**  
Foundation



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# 1. Workshop Overview

## **Background and Rationale to this Workshop:**

A little over a decade has passed since the Vision2020: Right to Sight initiative was commenced, and we are at the mid-point in the timeframe for achieving the goal of eliminating avoidable blindness. Each of the member countries has had varying degrees of success and face specific challenges in achieving this goal.

In response to the request of Member States at the Sixty-first World Health Assembly, an [Action Plan for the Prevention of Avoidable Blindness and Visual Impairment](#) was developed by WHO, and this was adopted by the Sixty second World Health Assembly. There are five objectives defined within the Action Plan for implementation during a five-year period from 2009 to 2013. Under each objective there are specific set of actions for WHO Member States, the Secretariat and international partners, which are intended to guide efforts to strengthen eye health in populations by developing comprehensive eye health programmes at national and sub-national levels.

This regional workshop on implementation of the WHO Action plan for the prevention of avoidable blindness and visual impairment in SEAR was organized from September 22-24, 2011 with the intention of taking these action plans forward into an execution phase as appropriate by each member country of SEARO.

## **Objectives:**

The objectives of the workshop were to:

- To review achievements to date in prevention of blindness and the Action Plan implementation,
- To review roles and responsibilities of the member countries pertaining to the Action Plan, to operationalize its implementation;
- To identify the issues and solutions at national and regional level in the implementation of the Action Plan.

## **Expected outcome:**

1. Updated information on the achievements and limitations in implementation of the Action Plan in the SEAR Member States
2. A clear understanding of the Action Plan's objectives and implementation priorities for Member States, the Secretariat, and international partners.
3. Agreed regional & national strategy for implementation of the Action Plan

**Participants:**

The workshop participants comprised of national prevention of blindness coordinators, heads of national blindness programs and representatives from Health Ministry, national VISION 2020 organization, major national service providers and INGOs in eye care. A total of 34 participants from 9 countries of the South East Asia Region (India, Nepal, Bangladesh, Sri Lanka, Thailand, Myanmar, Bhutan, Indonesia and Timor Leste) participated

**Organisers:**

This Regional Workshop was co-sponsored by the International Agency for the Prevention of Blindness (IAPB) and the office of the WHO-South East Asia Region. LAICO (Lions Aravind Institute of Community Ophthalmology), a unit of Aravind Eye Care System, Madurai in their capacity as a WHO Collaborating Centre for Prevention of blindness, was involved in the design and execution of the workshop which it also hosted.

## 2. WHO Action Plan – the 5 Objectives

### **OBJECTIVE 1. Strengthen advocacy to increase Member States's political, financial and technical commitment in order to eliminate avoidable blindness and visual impairment**

- Establish and support national coordinating mechanisms, such as national coordinators posts for eye health and prevention of blindness at health ministries and other key institutions, as appropriate
- Consider budgetary appropriations for eye health and prevention of blindness.
- Promote and integrate eye health at all levels of health care delivery.
- Observe World Sight Day
- Integrate eye-health preservation in health promotion agenda

### **OBJECTIVE 2. Develop and strengthen national policies, plans and programmes for eye health and prevention of blindness and visual impairment**

- Where sufficient capacity exists, develop national strategies and corresponding guidelines for the prevention of blindness and visual impairment; otherwise consider adapting those recommended by WHO
- Review existing policies addressing visual health, identify gaps and develop new policies in favour of a comprehensive eye-care system
- Incorporate prevention of blindness and visual impairment in poverty-reduction strategies and relevant socioeconomic policies.
- Involve relevant government sectors in designing and implementing policies, plans and programmes to prevent blindness and visual impairment.

### **OBJECTIVE 3. Increase and expand research for the prevention of blindness and visual impairment**

- Promote research by national research institutions on socioeconomic determinants, the role of gender, the cost-effectiveness of interventions, and identification of high-risk population groups.
- Assess the economic cost of blindness and visual impairment and its impact on socioeconomic development.
- Determine the impact of poverty and other determinants on the gradient of socioeconomic disparity in individuals' access to eye-care services.
- Include epidemiological, behavioural, health-system and health-workforce research as part of national programmes for eye health and prevention of blindness and visual impairment.

#### **OBJECTIVE 4. Improve coordination between partnerships and stakeholders at national and international levels for the prevention of blindness and visual impairment**

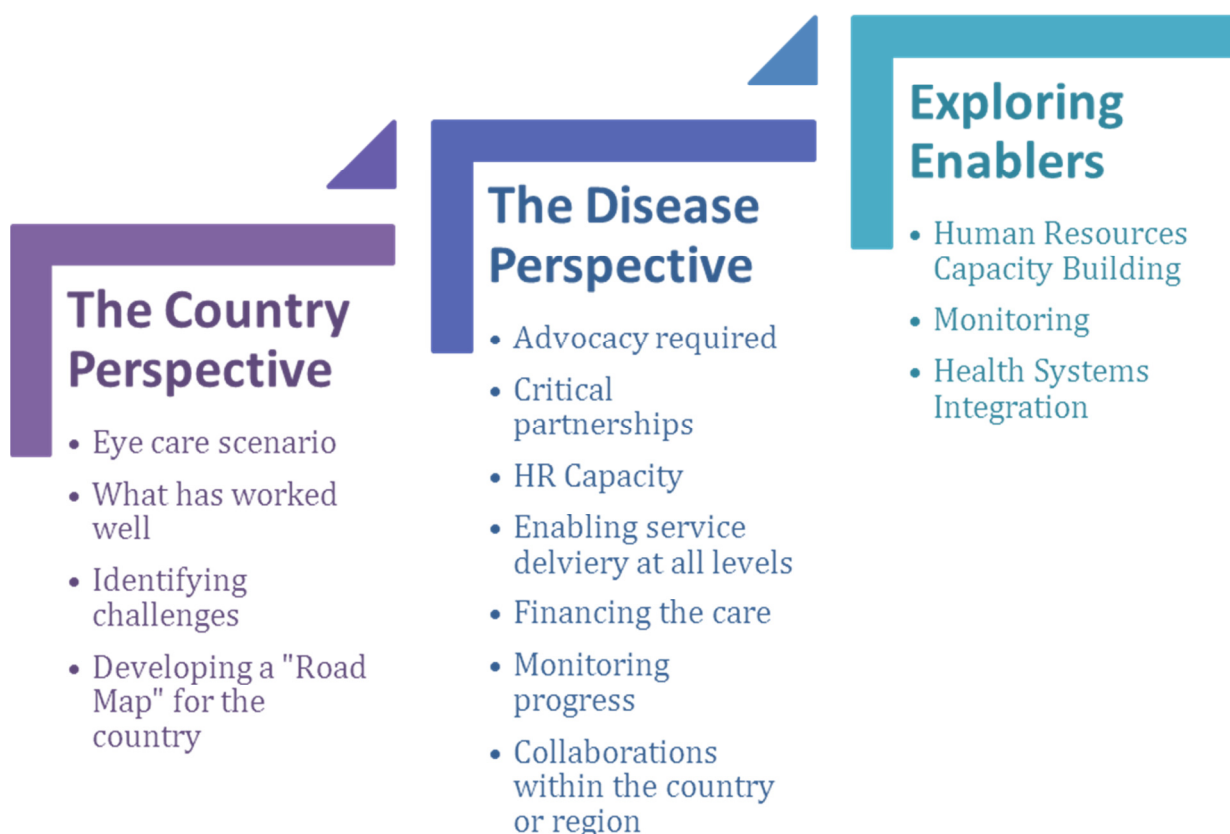
- Promote participation in, and actively support, existing national and international partnerships and alliances for the prevention of avoidable blindness and visual impairment, including coordination with noncommunicable disease control programmes and neglected tropical disease prevention and control.
- Promote partnerships between the public, private and voluntary sectors at national and subnational levels.

#### **OBJECTIVE 5. Monitor progress in elimination of avoidable blindness at national, regional and global levels**

- Provide regularly updated data and information on prevalence and causes of blindness and visual impairment, disaggregated by age, gender and socioeconomic status.
- Strengthen standardized data collection and establish surveillance systems using existing WHO tools (for example, those used for Cataract, trachoma and onchocerciasis).
- Provide regular reports using the WHO standardized reporting system, on progress made in implementing national blindness - prevention strategies and plans.

(**Source:** WHO Action Plan for the Prevention of Avoidable Blindness and Visual Impairment (2009-2013))

### 3. Workshop Design



The Action Plan was pivotal to the content of the workshop discussions and outcomes. The workshop was designed to develop strategies for better eye care service delivery from two perspectives:

#### From the perspective of each member nation:

Presentations by each country representative brought out **successful practices** in eye care service delivery. Through discussions, the **challenges of each country** were also elicited. Through small group work, a **detailed road map** for each country was developed considering the five objectives of the Action Plan.

#### From the perspective of each priority eye disease:

The work being done in each priority eye diseases was presented by experts in the field. A panel discussion that followed explored the challenges and possibilities to improve service delivery for the priority eye diseases:

- Primary eye care
- Cataract
- Refractive error
- Diabetic retinopathy
- Glaucoma
- Paediatric eye care
- Low vision

### **Enabling better eye care service delivery:**

Last day of the workshop was dedicated to the three main aspects that impact eye care delivery: human resources capacity building, monitoring and health system integration.

## 4. Workshop Flow:

**Introduction** to WHO's Action Plan for the Prevention of Avoidable Blindness and Visual Impairment (2009-2013)

**Presentations by member nations** on the extent of implementation of the Action Plan

Bangladesh  
Bhutan  
India  
Indonesia  
Myanmar  
Nepal  
Sri Lanka  
Thailand  
Timor Leste

**Presentation and discussion** of the extent of implementation of the action plan for priority eye diseases

Primary eye care  
Cataract  
Pediatric eye care  
Refractive Error  
Diabetic Retinopathy  
Low Vision

**Presentation and discussion** on *"How to enhance implementation of the action plan?"*

- Human Resource
- Monitoring
- Integration into health systems

**Group work and presentation** for each member nation on taking forward the implementation the action plan

- Developing the agenda for National Consultations
- Who should attend?
- Who should make this happen & who will finance it?
- When will this take place?
- Leveraging Collaborations: What can my country contribute or benefit from another country or the Region?

## 5. a. Bangladesh

### *What works well...*

**Strong networks:** The Bangladesh National Council for the Blind (BNCB) is a committee that draws from the expertise of people from different backgrounds and contributes towards a strong public private partnership. Vision 2020 committees have been formed at the district level in 30 out of the 64 districts with members from different strata of the society. Bangladesh has successfully forged a good network with the various international NGOs working in the country in implementing the national plans.

**Orienting healthcare workers in eye care:** The country has also worked towards strengthening the orientation and training of health care providers at all levels right from community clinics to specialized hospitals. Eye care messages are regularly disseminated through the Health Education Bureau. Coordination meetings are regularly held with the Health Minister & Health Advisor. Orientation on Primary Eye Care for PHC workers of Upazilla Health Complexes and community clinics has been done in order to integrate primary eye care in community clinics.

**Eye care workforce:** The HR pool to satisfy the requirements of eye care is being developed by the introduction of training programmes such as the Refraction course for 1 year secondary school students with science background. Certificate course have been started for ophthalmic assistants and ophthalmic technicians.

**Ensuring quality of eye care:** Quality protocols for eye care have been defined for the country. SICS guidelines including a manual for SICS management and sterilisation protocols focusing on quality assurance have been developed. This is extensively adopted by NGO hospitals. Further Treatment and Examination Protocol have been developed for other cadres:

- Primary Eye Care Manual for Primary Health Care Workers
- Guideline for OT & Ward Management for paramedics
- Guideline for Counselling in Eye Care

Standard formats for reporting have been developed for cataract surgery. These reports are being sent to IAPB and WHO regularly. Cataract Surgical Outcome Monitoring (CSOM) is being piloting at the institutional level. Further, in order to improve paediatric eye care services, model child eye care centres have been established in 16 districts.

**Eye Care Research:** A national level research body has been established to promote research initiatives in the country. Recently restructured, this body is now coming up with research initiatives that would help in improving eye care service delivery. The apex eye institute, National Institute of Ophthalmology (NIO) and tertiary eye care and training centres are involved in research that includes epidemiological & socio-economic determinants of blindness on a continuous basis through their PhD and other programmes. The Bangladesh Medical Research council is to undertake research related to eye care in collaboration with the NIO.

**Country's commitment to eye care:** There exists a National Eye Care Plan underway (Strategic plan for 2011-2016). Similar plans developed previously have been working well. Government commitment for the eye care is seen through the involvement of ministry in the National programme.

## Challenges:

**Human resource constraints:** Currently paramedics are not allowed to do refraction. This requires higher numbers of professionally trained manpower. There is no policy at the central level to strengthen the quality of the optometrists and to authorise them to take up the work load from the ophthalmologists.

The retention of ophthalmologists in the country is a problem. Also, many of the qualified ophthalmologists do not perform surgery.

**Awareness:** Uptake for services such as Low vision is very low due to poor awareness

**Priority for eye care:** The country has allocated only 0.1% of its development budget in the health budget for eye care (Tk. 22 crores for 5 years). As there is a common health budget the priority for eye care is low – mainly because line directors are from different health fields. V2020 committees are not active in all the districts.

**Quality:** Government hospitals have not yet started practicing SICS for cataract surgeries.

**Coverage:** It is necessary to conducting periodical surveys to estimate the extent of work being done and understand about service delivery coverage levels. Also, the focus of Bangladesh's eye care is chiefly on cataract.

**Upscaling:** Scaling up to national level from the institutional level to the national level

## The way forward...

**To achieve consensus in the country for the eye care priorities identified:** A plan has to be drafted to address the problem of cataract blindness. This can be conducted as a workshop with focus group discussions and through opinion polls through the website. This has to be approved by the apex body (BNCB). A separate operational plan should be developed for eye care with a dedicated line director who is an ophthalmologist.

### Stakeholders to be involved:

- Ministry of Health and Family Welfare
- Ophthalmological Society of Bangladesh
- WHO
- Eye hospitals government, NGOs and private sectors
- Donor agencies
- CBOs
- Media
- Ministry of Education

**Developing the Agenda for National Consultations:** National level consultations should be held to discuss:

- Disease burden
- Human resource and infrastructure for eye care
- Improving clinical outcomes of cataract surgery
- Monitoring national eye care programmes
- Universal coverage of eye care services

**Taking this forward:** The Line Director should take this forward working along with the National and District V2020 Committee, National and international NGOs and WHO. This should be done by Dec 2011.

**Collaborations that can be leveraged:** The success factors that have contributed to Bangladesh's eye care programmes can be shared at regional meetings of eye care institutions.

**Support required from IAPB or WHO to achieving this Action plan:**

- Guidelines and tools
- Higher level advocacy
- Assistance in developing an information system
- Capacity building

## 5. b. Bhutan

### *What works well...*

**Strong network with Government:** The Royal Government of Bhutan made eye care programmes an important component of non-communicable diseases within the Ministry of Health. The involvement from the government is commendable, especially the ministry of education & labour. Employment agencies and their support to eye care programmes are also appreciable. The personal commitment from the Queen has helped to scale up the eye care programme within a short duration.

The national and international organisations in the country have also started working on eye care programmes and made progress. The current government has allocated considerable percentage of the budgets from overall health budget for supporting eye care programmes in the country. The Himalaya Cataract Project (HCP) is supporting USD 100,000 per year for supporting salary and infrastructure facility in the country. The funding support from the current Government along with the funding support from Himalaya Cataract Project (HCP) is sufficient to improve eye care programmes in the country.

**Strong Supply Chain:** The policies for procurement of drug and other consumables in the country have been improved. Department of Medical Services is responsible for the supplies of drugs and non-drugs and they have performed this well.

**Ensuring Quality of eye care:** The standard operating procedures (SOP) have been developed and the team is working on improving overall standards in the hospital set up and outreach programmes in the country. The regular morbidity reporting has been done at camp, clinic and hospital level.

**Eye Care Research:** A Rapid Assessment of Avoidable Blindness (RAAB) was completed during 2009-2010 and the team is in the process of developing actionable guidelines based on outcomes of the study. The results of corneal ulcer study done together with three countries (India, Nepal and Bhutan) have been instrumental for the country to develop a model for prevention of bacterial ulcers at the village level. The Diabetic Retinopathy Screening programme has been shown results with increasing magnitude of diabetes in the country.

### *Challenges*

**Lack of focus to Eye Care programmes:** The country has not formed a separate division for blindness control under the ministry of health to support eye care programmes and take it forward. There is a strong need to improve state level commitment towards political, financial and technical support. The national guidelines for the country for an eye care programmes are not developed, hence the country has to follow WHO guidelines. The current policies on eye care need to be reviewed. There are very few INGOs are working in the country to support eye care programmes. Incorporation of prevention of blindness and visual impairment in poverty-reduction strategies and relevant socioeconomic policies is still pending.

**Research:** Involving in more research activities is a challenge since the infrastructure and HR capacity is low to support the eye care research activities.

**Eye Care Data:** Comparison of eye care data with the other countries is difficult since each country is following different formats.

### *The way forward...*

**To achieve consensus in the country for the eye care priorities identified:** The National Strategic Plan of Action should be formulated and endorsed by the government of Bhutan. The Vision 2020 national team should be formed and consensus obtained.

**Stakeholders to be involved:**

- Ministry of Health, Royal Government of Bhutan
- Gross National Happiness (GNH) commission of Royal Government of Bhutan
- Bhutan Medical and Health Council (BMHC)
- Education Ministry
- WHO/IAPB
- Himalaya Cataract Project
- Other INGOs
- NGOs

**National level consultations should be held to discuss on:**

- The political, financial and technical commitment of the government
- How to increase CSR and quality services
- Training of a team for Retina Vitreo (VR) services
- Equipment supply
- Enhancing eye care awareness
- Preparing national plans for eye health to enhance cataract services and to initiate DR services

**Taking this forward:** The Ministry of Health, ophthalmologists and other eye care professionals in the country are responsible to take this work forward. They also should approach WHO, IAPB and eye care INGOs working in other countries for consultations to enhance eye care services in the country. This should be done in the year 2012.

**Collaboration that can be leveraged:** Organisations with experience like Aravind Eye Hospital can be involved in development of national plans. Study visits can be planned to visit eye care programmes in other countries.

**Support required from IAPB or WHO to achieving this Action plan:**

- Provide technical and funding supports
- Conduct consultative workshops
- Provide facilitation with the government

## 5. c. India

### *What works well...*

**Country's commitment to eye care:** India has a well-developed national eye care programme (National Programme for Control of Blindness). Its 11th five year plan focuses on comprehensive eye care delivery. Support to regional eye institutes, NGOs and private hospitals is provided by the government through the national plan. Funding support is provided to the so far poorly addressed north-eastern states to build infrastructure and HR.

Specific budgetary allocations are made to support activities of regional institutes of ophthalmology, medical colleges, district and sub-district hospitals, and tele-ophthalmology units. Assistance is also provided for maintenance of ophthalmic equipment. Recurring Grant-in-Aid for NGOs is being provided for management of eye diseases other than cataract.

National Programme for Control of Blindness was launched in 1976 as a 100% centrally sponsored programme to reduce prevalence of blindness from 1.4% to 0.3% and is working very well. This integrated public private partnership for cataract work which has been underway for more than 20 years is now the best model health program in the country. The budgetary allocation to eye care has been increased considerably over the years.

**Coverage:** Eye care is an integral part of the national rural health mission (NRHM) plan. This includes structured layout of service delivery addressing all levels of care from primary to tertiary care. Tele-ophthalmology units in inaccessible areas or areas lacking ophthalmologists have been set up to enable accessibility. School children screening programme has been instituted through the "education for all" scheme.

Multiple IEC activities at the central and state level is carried out in collaboration with various programmes of the ministries of education and health. Awareness programmes target the public through radio, mobile service providers, Cinema halls, Transport department, education department, corporate sectors.

The District Blindness Control Society (DBCS) is a decentralized wing of NPCB created an access for the unreached population to access eye care at free of cost – specific to cataract. It is a successful PPP model – with a lot of NGOs involvement.

As per the rapid survey on avoidable blindness conducted during 2006-07, the prevalence of blindness has come down to 1% as compared to 1.1% during 2001-02.

**Quality:** In order to improve quality of eye care delivery, cataract surgeries with IOL implantation has been emphasised – this is being monitored. Surgeries in makeshift camps have been banned. The use of modern techniques and quality eye equipment is emphasised.

**Eye care Research:** National surveys including RAAB are being undertaken involving NGO service providers across the country; these surveys are undertaken at the programme level by the Blindness programme that serves as a basis for rolling out eye care service delivery programmes.

Some of the programme level surveys conducted include:

- National survey on Magnitude and Causes of Blindness-1986-89.

- ICMR conducted a nationwide Survey in 1971-74: which led to the launch of NPCB - led to developing a programme for service delivery
- The National Trachoma Survey of 1959-63.
- The National Survey on Blindness in India-1986-89.
- A Rapid Assessment of Trachoma in 2006 in previously known hyper-endemic states
- A population based survey in Bulandshahar (UP)-2007
- A Rapid Assessment of Trachoma in A& N island-2010.
- National survey of Blindness and Visual outcome after Cataract: 2001-02.
- Rapid Assessment of avoidable Blindness in the year 2006-07.

**Monitoring:** An integrated Health Management Information System is being planned to integrate eye care data across the country. 5% of all data submitted is cross verified by the district programme manager. Regular evaluations are carried out by independent agencies.

## ***Challenges:***

**Coverage:** Service delivery inequity is prevalent – there is a wide difference in performance among states. In the 12<sup>th</sup> five year plan, which is under consideration, the emphasis should be on comprehensive eye care services with quality improvement. There are few private & NGO eye care providers in the north & north eastern states, which leads to less CSR level.

**Human resource:** Training needs to be strengthened with impact assessment built into it.

**Research:** Operational research to be promoted to improve design of eye care services. Institutional research in the newer initiatives to be supported both in government and private/NGO sector.

**Eye donations:** The current eye donations are insufficient to meet the need. It is essential to further strengthen focus on this.

## ***The way forward...***

**To achieve consensus in your country for the eye care priorities identified:**

- Reduce the prevalence of Blindness from 1 to < 0.3%
- Provide Comprehensive and Quality Eye care
  - HR planning and capacity building
  - Infrastructure development
  - Standardization and accreditation of training of other cadres or eye care personnel
  - Facilitate eye care services to bilaterally blind

(These priorities already articulated in the 11<sup>th</sup> Plan and will be emphasized when the 12<sup>th</sup> plan is finalized)

**Stakeholders to be involved:**

- Central and State Governments
- NGOs & INGOs
- Private practitioners
- Community

- Institutions, Medical Colleges & RIOs
- Professional Associations / Bodies
- Ophthalmic Industry

**Developing the Agenda for National Consultations:** Working Group and Steering committees of the ministry and the Planning commission

**Taking this forward:** This will be taken forward by the national and state governments, NGOs, INGOs and stakeholders in the community

These plans are existing and on-going. Targets and deadline are already set.

**Collaboration that can be leveraged:**

- Training
- Sharing of Experience, Protocols, Best practices
- Technology
- Supplies of Ophthalmic equipment and supplies
- Institution and Capacity Building

**Support required from IAPB or WHO to achieving this Action plan:**

- Bringing good practices
- Sharing experiences
- Technical support

## 5. d. Indonesia

### *What works well...*

**Strengthen national eye care programmes:** The directorate of Basic Health Efforts is currently coordinating eye care programmes in the country. Eye care programmes are integrated with general health programmes at all levels across all sectors. Eye care programmes are developed in partnership with WHO and INGOs. The National committee of VI and Blindness Prevention was formed by Presidential decree.

National Strategy Plans for Visual Impairment and Blindness Prevention was started to achieve the goals of Vision 2020 in 2005. The country's Healthy VISION 2020 strategy has developed national policies, plans and programmes for eye care under the constitution of health. The blindness control activities are managed as joint responsibility between government and community. Eye health programs are integrated with other health programs such as school health programs for early detection and periodic monitoring; work force health programs, work force protection and nutrition programs – vitamin A Supply. Coordination among national, Provincial & Districts vision 2020 committee are strengthened through regular meetings to co-ordinate eye care resources & activities.

The Government insurance programme (*Jamkesmas*) has been initiated for supporting eye care services for poor population especially to cover the cost of cataract operations, glasses and other curative eye care services. A routine reporting system has been established by provincial health office. A strong monitoring system has been developed by Ministry of Health to monitor the performance of eye care programme at provinces and district health office

**Eye Care Research:** Ministry of Health involved in conducting blindness survey and a study on causes of blindness was conducted recently in 2007. A basic research survey conducted at the national level by Ministry of Health has helped to capture the current eye health data.

**Awareness:** World Sight Day celebrated every year since 2005, in the form of free cataract operations, community seminars and counselling.

### *Challenges:*

**Challenges in implementation of national programmes:** Eye Care is not considered as a priority health programme within the Ministry of Health. Hence budgetary allocations for eye care programmes are comparatively very low. The government insurance scheme is not utilized completely to do free cataract surgeries.

The current national committee has less authority. Efforts are being taken by the new director to strengthen the power.

**Lack of support from NGO and INGO:** The participation of NGOs and their contribution to eye care is not sufficient. 80% of services are done by the government sector and only 20 % of services are offered by the private sector. Also there are only few voluntary organizations to support eye care in the country. At present, there is very limited funding support and collaborations with INGOs.

**Lack of Resources:** Currently, there is no special attention on improving human resources and infrastructure facility available for eye care in the country. The existing eye hospitals and human resources are distributed unevenly.

**Cost:** High cost of quality treatment, drugs and consumables makes eye care service delivery very expensive.

**Research:** Very few research studies are being carried out in the field of eye care. There is insufficient data to monitor progress of the eye care work being done.

## ***The way forward...***

**To achieve consensus in the country for the eye care priorities identified:**

***Disease priorities (tentatively):***

- Cataract
- Refractive Error/Low Visions
- Childhood Blindness
- Diabetic Retinopathy
- Glaucoma

***Achieving consensus at the national level***

- Appoint a new committee following Presidential Decree
- In the meantime, review the priority in the relation of existing action plan with stakeholders (PERDAMI, other Ministry, etc)
- Advocacy to all stakeholder to achieve consensus

**Stakeholders to be involved:**

- Ministry of Health
- Ministry of National Education
- Ministry of Social Welfare
- Ministry of Labour
- Local Government
- PERDAMI (IOA)
- Indonesian Optometrist Association
- PERTUNI (Blindness Association)
- Academic and Trainings Institutions
- Local NGOs
- INGOs

**Developing the Agenda for National Consultations:**

- National Meeting to review The Action Plan and formulate The Yearly Plan based on the priorities identified
- Implementing the action plans and yearly plan

**Taking this forward:** The ministry of Health, National Committee and local Government are responsible to take this forward. Financial support should be provided by the Government (MoH and other Ministries), NGOs and INGOs.

ACTIONS	TIMELINE
Appointing a new committee following Presidential Degree	2012
review the priority in the relation of existing action plan with stakeholders (PERDAMI, other Ministry, etc)	Nov 2011
Advocacy to all stakeholder to achieve consensus	Dec 2011
National Meeting to review The Action Plan and formulate The Yearly Plan based on the priorities identified	2012
Implementation of Actions plans and yearly plan	2012 - 2015

**Collaboration can be leveraged for:**

- Sharing of experience
- Research

**Support required from IAPB or WHO to achieving this Action plan:**

- Advocacy
- Technical Assistant
- Financial supports
- Evaluation

## 5. e. Myanmar

### *What works well...*

**Country's commitment to eye care:** The country has a budgetary allocation for the prevention of blindness (540 Million Mks). The country has several public-private partnerships for eye care. The country has collaborated with WHO & Helen Keller International for eye care research studies. The 2010 RAAB done in 3 districts was supported by the WHO. The Helen Keller foundation is also helping the country develop a national programme.

**Coverage:** Eye care is well integrated with Primary health care – the health staff are all trained in eye care. INGOs get government support to conduct mass cataract surgery activity.

**Eye care data:** Several of the hospitals systematically monitor the cataract surgical results. The country's secondary eye care centres send a monthly report on the blindness prevention program to the program manager in the department of health and an annual report to the Ministry of Health.

### *Challenges:*

**Human resource:** The country does not have enough ophthalmologists at the district level hospitals.

### *The way forward...*

**To achieve consensus in your country for the eye care priorities identified:**

- To report to Director General about action plan of WHO on Prevention of avoidable blindness.
- Address the country's huge cataract backlog

**Stakeholders to be involved:**

- Director General of Department of Health.
- Dy. Ministers for health
- Minister for Health.
- Chairmen of National Health Committee.
- INGOs , NGOs, Private sectors
- Well - wishers
- Religious leaders
- Ophthalmologists

**Developing the Agenda for National Consultations:**

- Presentation on WHO's action plan on Prevention of avoidable blindness
- Presentation on causes of blindness in Myanmar
- For human resource development (Ophthalmologist, MLOPs, Ophthalmic assistants)
- Developing well equipped secondary eye care centres.
- Estimating financial requirement for prevention of avoidable blindness.
- Partnering with INGOs and private sector in eye care delivery
- Awareness for avoidable blindness

**Taking this forward:**

- Minister for health and Finance will be the decision maker for more financing for elimination of avoidable blindness with the permission of National Health committee.
- This will take place within one to two years.

**Collaboration can be leveraged for:**

- Assistance in cataract surgery by sending ophthalmologist who is very surgically active.
- Participating in regional conferences and workshop for sharing the experience.

**Support required from IAPB or WHO to achieving this Action plan:**

- WHO and IAPB can assist us by technical, Financial and material supports.
- Advise the ministry on how to achieve the elimination of avoidable blindness in our country.

## 6. f. Nepal

### *What works well...*

**Government Support:** The Apex Body For Eye Health: After launching of Vision 2020 in 1999 the Apex Body for Eye Health was formed at the ministry of health. From then on, there has been increasing Government involvement and commitment in recent years. Regular workshops are conducted under the aegis of the Apex Body. The government is now preparing to integrate the primary eye care in to primary health care at grassroots level of health care system. There has also been government support for Zithromax distribution in trachoma endemic area and National Vitamin A distribution Programme. The percentage allocation from health budget for eye care: 6.5%

**Development of the NGO sector:** In the early days, all the government doctors were deputed to INGO hospitals. As a result, the INGO sector developed well. The NNJS has developed into a good Public-Private partnership and coordinates with MoH and different INGOs and NGOs.

**Good Research and Data:** The data from the National RAAB Survey is helping the country compare the need vs actual performance. Apart from this, prevalence surveys for Refractive Errors and Presbyopia, Glaucoma, Diabetic retinopathy, are conducted sporadically mainly by NGOs. All hospitals in Nepal have a computerized Medical Registration / IHMS. There is a central Data Bank at NNJS that consolidates all the data from the NNJS eye hospitals.

**Country's Commitment to Eye Care:** A National Strategic Plan 2001 – 2020 was prepared in 2001 and a revised plan is underway. The country has allocated 6.5% of its healthcare budget to eye care. The country also conducted a midterm review of Vision 2020 Nepal in 2011.

### *Challenges:*

**Integration with national health program:** There is a need for more integration of programs like NNJS with government services. This will improve the level of government involvement and commitment to eye care. Currently there are no permanent eye care services below the district level. Also, the Apex Body for Eye Health needs to be given more authority to form and modify policies.

**Human Resources:** One reason for the lack of permanent facilities in the sub district level is the frequent transfer of government staff (trained by NGOs).

### *The way forward...*

**To achieve consensus in your country for the eye care priorities identified:** The revised National Strategic Plan (2002 – 2019) will need to incorporate the emerging priorities on eye health and recommendation of MTR. The Action Plan will need to be endorsed by the MoHP through ministerial cabinet

#### **Stakeholders to be involved:**

- Ministry of Health and Population,
- Relevant sectoral ministries
- National planning commission
- EDPs, INGOs, NGOs involved in eye care and other related stakeholders

- WHO/IAPB
- Training Institutions
- Professional Associations (Nepal Medical Council, Nepal Ophthalmic Society, Nepal Optometrist Society, Nepal Ophthalmic Assistant Society, Nepal Health Professional Councils etc.)
- Ophthalmic Industries

**Developing the Agenda for National Consultations:** National level consultations should be held to discuss:

- Integration of Eye Health in to Primary Health care
- Expansion of Eye Care in to PHC level and cataract surgical service to District level.

**Taking this forward:** The Apex Body for Eye Health (Ministry of Health and Population of Nepal) will need to take the lead along with INGOS and EDPs. This should be done from 15 July, 2012.

**Collaboration that can be leveraged:** Technology transfer/Experience sharing, skill development, HR Development and Research

**Support Required from IAPB or WHO to achieve this Action plan in the country:**

- Advocacy
- Monitoring and evaluation
- Financial support and resource mobilization
- Technology and Skill Transfer
- CMEs, Seminar and Symposium, Workshop

## 5. g. Sri Lanka

### *What works well...*

**Country's commitment to eye care:** From the total health budget, 1.5% has been allocated for eye care (1 billion rupees). Five year National Plan for Prevention of Avoidable Blindness in Sri Lanka (2007-2012) has been implemented and for better coordination and monitoring, one year plans for each year has also been established. The broad components of the National Policy include infrastructure development, human resource development and disease control. health is given free of cost for the citizens by the government. A unique decentralised health system ensures that each and every village is covered. Also there is a well-established primary health care system that integrates primary eye care.

**Networking and alliances:** VISION 2020 Programme has been recognized as a National Body by IAPB. The VISION2020 programme for Sri Lanka includes a primary eye care programme that is incorporated into the primary healthcare Programme, a Childhood Blindness Programme, Programmes for low vision and refractive error (including school screening and free spectacle programme), glaucoma, diabetic retinopathy, and cataract. An urban eye care programme has also been developed.

Focal personnel are identified to be accountable for each area and one eye surgeon heads each priority disease area. the VISION 2020 steering committee comprises MOH, College of Ophthalmologists, Other ministries - Education & Social services, Provincial & District health authorities, INGO's & NGO's. The government liaises with private organizations for developing paediatric eye unit, optical workshop, eye operating rooms etc. There are collaborations with foreign universities for higher education. Good quality eye ball collection & utilization is also strengthened with through collaboration.

**Eye care workforce:** The midwives are trained to check vision. Other trained staffs besides the ophthalmologists also perform cataract surgeries.

**Eye care research:** Proposed National Blindness Survey will be executed shortly to develop better understanding about the magnitude of blindness in the country. Other major eye care research initiatives are as follows:

- Primary Eye Care Research - Evaluate extent of utilization of PEC services
- Vision screener research- Assessing the feasibility of introduction of new vision screener tool for school screening

**Monitoring and evaluation:** There is a system established to evaluate extent of utilization of primary eye care services and monitoring happens at all levels (Division, District, Provisional, and National). The V2020 secretariat has an online monitoring system. There also exist a System to capture referral information and the online web-based data entry at district level.

## Challenges

**Man power and productivity:** Ophthalmologist turnout each year is insufficient to meet the workload in the country. In addition, the productivity is also low.

## The way forward...

**To achieve consensus in the country for the eye care priorities identified:** The knowledge acquired/ deliberations made, will be discussed with and a written report submitted to:

- The focal persons of V2020 Sri Lanka
- The National Steering Committee
- Annual review meeting of V2020 Sri Lanka

The recommendations from the above forums will be incorporated in to the next 5 year strategic plan

### **Stakeholders to be involved:**

- The Ministry of Health (MoH)
- College of Ophthalmology
- Provincial and District Health authorities
- INGO / NGO forums
- Other Govt. departments

### **Developing the Agenda for National Consultations**

- Establishment of a National Council for Elimination of Blindness
- Formulation of a Policy Document for Eye Care
- Guideline and protocols are to be developed for priority diseases
- Conduct National Workshop with the participation of Regional Experts in Eye Care

**Making it happen and getting it funded:** MoH and College through V2020 SL programme will assure the implementation of the above programme. MoH and Donors will finance these initiatives.

**Timeline:** Initial discussions with FPs will be commenced within a month. Further action plans and timelines will be finalized at the next V2020 National Steering Committee Meeting to be held in Dec. 2011

### **Collaborations that can be leveraged:**

- Sharing of experiences at the regional and international conferences
- Organizing study visits to observe eye care services
- Exploring the possibilities to provide to offer training for eye care professional

### **Support required from IAPB or WHO contribute to achieving this Action plan:**

Assistance required for conducting proposed national blindness survey and research. Facilitation of training of eye care professionals in the other countries will be helpful. Provide technical support to develop protocols for disease control. Support the development of HIMS in eye care.

## 5. h. Thailand

### *What works well...*

**Country's commitment to eye care:** Thailand has been successful in integrating primary eye care into primary health care. The Prevention of Blindness Committees was established in the country since 1978. There is Increasing financial commitment for eye care programme from UC scheme i.e. reimbursement for cataract surgeries with IOL. Through collaboration with universities and INGO's the government has established the disability act which will have positive impact in the Low Vision care.

**Awareness creation & Promotional activities:** World Sight Day and World Glaucoma Day are celebrated with various activities. On the King's 84th Birthday, services for Diabetes and diabetic retinopathy (DR) were set up. Screening programmes for DR (with non mydriatic fundus camera) has been established all over the country.

**Research and publication:** National Blindness and Visual Impairment Survey is conducted every 5 years (last one was in 2006). Publication of Thai Journal of Public Health Ophthalmology is another major activity under this area

### *Challenges:*

**Priority for eye care:** There is no active National Eye Care Plan for the country and there is lack of comprehensive government support for eye care programmes.

**Eye care work force:** The policy on human resource for eye health is driven by the Royal College of Ophthalmologists

**Referral network:** Currently there is no referral mechanism for problems such as DR and other speciality diseases

**Eye care research:** Research mainly occurs in the universities and medical schools. Data capturing is happening but there is no mechanism for analysing the data to aid in planning

### *The way forward...*

**To achieve consensus in the country for the eye care priorities identified:** Revitalizing the effort to create the National Eye Care Plan (NECP). The NECP should be based on two principles: integration of primary eye care into primary health care (community-based primary care with optimized referral system) and using this comprehensive and quality eye care to strengthen the health system. The plan should include situation analysis, prioritization, concrete action plans, monitoring and evaluation. Proper costing is to be done for the plan with involvement of all stakeholders.

**Stakeholders to be involved:**

- Ministry of Public Health
- Ministry of Education
- Provincial and regional representatives
- Royal College of Ophthalmologists
- Medical schools
- Patient advocacy groups

**Eye Health Information System:** The information system needs to be strengthened in order to make use of the available data for decision making and future planning.

**Taking this forward:** Mettapracharak Hospital can represent Department of Medical Services and serves as the secretariat to convene workshops to draft the National Eye Care Plan

**Support required from IAPB or WHO to achieving this Action plan:** IAPB can provide technical support to organize and convene effective workshops and strategic planning exercises.

## 5. i. Timor Leste

### *What works well...*

**Countries commitment to eye care:** Eye care plan established as part of the larger National Health Plan. There is active involvement from the President in all eye care related initiative. Despite other competing national health priorities, eye health was included in the ministry's strategic planning framework. The ministry of health recognises the importance of eye health services due to the significant personal and economic impact of blindness; most blindness is preventable or treatable at relatively little cost. The National Eye Health Strategy (5 years) developed in 2006 with a goal to ensure adequate provision of efficient and appropriate eye health services for the prevention and treatment of blindness and vision impairment. Specific targets have been established around the main focal areas - equity, quality, acceptability & efficiency.

**Eye Care Research:** Eye health survey carried out in the year 2005 led to developing five years eye health care strategic plan

**Networking and alliances:** There is collaboration with a pharmaceutical company to establish telemedicine facility. Partnership has been established with primary schools for Braille training. Currently working with local disability NGOs such as Fuan Nabilan and East Timor Blind Union (ETBU) to help provide rehabilitation services. There is support from Cuba, Australian and New Zealand governments for the blindness prevention activities.

**Quality Assurance:** Process for monitoring of cataract surgery outcome has been established.

### *Challenges:*

**Awareness level** in the community about blindness and visual impairment is very low

**Affordability:** Spectacles are not provided free of cost to the patients. It's a challenge as the current charges are not affordable for the patients.

**Getting started:** Since it is a new country, right now the focus has been to develop infrastructure to deliver eye care services

### *The way forward...*

**To achieve consensus in the country for the eye care priorities identified:** Priorities identified for disease control are as follows:

- Cataract
- Uncorrected refractive errors and low vision
- Childhood eye care
- Diabetic Retinopathy
- HR and Infrastructure development
- Rehabilitation services

**Stakeholders to be involved:**

- Ministry of Health
- Ministry of Education
- Ministry of Solidarity

- National and international NGOs

#### **Developing the Agenda for National Consultations**

- Review long range national plan (2010 - 30)
- Revise targets based on available data

**Making it happen and getting it funded:** Timor Leste government ministries should take these ideas forward with assistance from partners. Joint funding from Timor Leste, donor countries and donor organisations are to be utilised for this purpose.

**Timeline:** Most of these initiatives are to happen over rest of 2011 and in 2012. Blindness prevention initiatives are to be given considerable weightage in the 2<sup>nd</sup> 5 year Eye Health strategy for 2012 - 2016

**Collaborations that can be leveraged:** As fledgling country, Timor Leste will welcome appropriate assistance from other countries, both financial and in-kind. We welcome opportunities to collaborate in appropriate ways – wouldn't it be nice for all of us to be involved in contributing to this new country's development?

#### **Support required from IAPB or WHO to achieving this Action plan:**

- Technical advice and assistance where required and appropriate
- Policies and guidance for appropriate research to help us ensure that we have good information to guide our decisions and plans.

## 6. a. Cataract

**Service Delivery:** Cataract has received relatively higher priority over the past two decades. In some countries the government supports cataract service delivery and eye care providers receive professional and on-going support. However, in some countries there is no formal national eye care programme or it receives little priority. Another complication is that eye care services and infrastructure are not uniformly distributed in all districts or provinces.

**Critical Partnerships:** Robust cataract service delivery models have often leveraged linkages with international NGOs and professional organizations such as training institute and eye hospitals. Partnership with public, private and voluntary sectors are necessary for effective service delivery.

Screening can be mainstreamed by orienting the government health system and facilities, including the army to screen for basic eye conditions like cataract and refer them to eye care providers.

**Human Resource:** Training ophthalmologists in manual SICS has been an important step in delivering cost effective treatment in developing countries. However, this remains a bottleneck in certain nations where there is insufficient training infrastructure. Training in Phaco is also essential to offer the services to those who can afford it. It is the surpluses generated from this that can make cataract services self-sustainable.

**Paediatric care:** The cost of Paediatric eye care services is significantly higher than cataract services and this makes treating paediatric cataracts a challenge. This cost should also be addressed in the plan.

**Compliance:** Where quality of care is affected by poor follow up care, it is essential to increase the follow-up rate through effective counselling. Compliance can also be encouraged by providing low cost post-operative reading glasses and incentivising follow up to the health workers.

**Monitoring:** A robust documenting and reporting system should be in place to provide intelligence about the progress being made. Definite protocols should be established to monitor quality and surgical outcomes. Surgery technique must be appropriate to the cataract condition. Indicators such as the following should be monitored closely:

- Visual outcome (1-3 weeks after surgery) with best correction
- Proportion of IOL implantation
- Proportion of complication
- Average time of surgery

Knowledge Attitude and Practice (KAP) surveys in the community should be conducted to identify knowledge gaps.

## 6. b. Refractive Error

**Service delivery and Coverage:** Refraction is one of the main areas of focus in comprehensive eye camps. This is further addressed through school screening camps and through camps conducted for employees of large industries and other workplaces. Such integration of refractive error into community eye care is essential and this can even make the service self-sustainable through the sale of spectacles.

We should advocate making preschool refraction screening mandatory for all schools. We can also proactively market employee screening in industries.

Mechanisms to deliver affordable spectacles on the spot should be developed to enable better acceptance and uptake by the patients. The competence for spectacle dispensing and inventory management should be in place. It has been observed that usage is poor even where free spectacles have been dispensed among school children as they don't like the looks. Hence, it is important to focus on the cosmetic aspects of the frames.

**Human Resource:** Courses that train optometrists and refractionists should be made attractive as professional courses.

**Challenges:** Coverage of refractive error still remains low as there is poor awareness on the need for correction. Accessibility to eye care providers who offer quality affordable refractive correction remains an issue. Refractive error in outreach work is also sporadic.

## 6. c. Childhood Blindness

**Critical Partnerships:** Addressing childhood eye diseases involves working with diverse stakeholders. It is essential that professionals work with the government. Child eye care should be incorporated into the nation's health plan and sufficient budget allocation should be made. Linkages with schools, paediatric and neonatal care providers, community health workers, traditional healers, drug retailers, community leaders should be forged to ensure penetration of paediatric eye care services.

Collaborations with INGOs can be leveraged as they have worked in the field and have developed some level of expertise in handling a particular disease. Linkages with academic institutions can be developed for research collaborations.

**Human Resource:** POLTC (The Paediatric Ophthalmology Learning & Training Center) Approach to build specialized team for paediatric eye care is a comprehensive approach that trains Ophthalmologist, Anaesthetist, Optometrist, Nurse, Counsellor and Outreach coordinator. Structured curriculum & training material can produce competent personnel for all cadres of paediatric ophthalmology. However, Retention of personnel in the trained paediatric team remains a challenge.

Moreover, all general ophthalmologists should be oriented to screen and refer paediatric cases for tertiary level care. They should be trained to screen for ROP.

## 6. d. Diabetic Retinopathy

**Focus on DR:** Some governments (as in India which has a large diabetic population) have allocated a specific amount in the eye care budget for DR in 11th five-year plan. A special programme for control of diabetes has been instituted under the Indian NRHM (National Rural Health Mission). Similarly DR has been identified as a key component in Sri Lanka's V2020 plan and the country's five year plan.

Governments can provide support such as financial support in the form of reimbursement for laser treatment and grant support to develop DR services in eye hospitals.

**Establishing protocols:** The diabetic retinopathy manual has been launched in India with support from SSI. DR screening should be made compulsory in all the hospitals. Detailed protocols have to be developed for screening and treatment (both medical & surgical).

However, there is not enough data regarding DR prevalence and coverage levels.

**Critical partnerships:** Only 7-8% of the ophthalmologists are trained in DR. The awareness among diabetologists also is very poor.

In the rural areas, medical officers, paramedical personnel, NGOs, primary health workers, teachers and self-help groups can be oriented to spread awareness. Similarly in urban areas, the media, Lions/Rotary Clubs, diabetologists, medical associations, general practitioners, paramedical workers, and laboratories can be enrolled to sensitise diabetics about DR. Moreover, nurses, ophthalmic assistants and project managers are also to be trained in setting up DR services.

It is essential to institute effective counselling which is very vital and has to be carried out by trained counsellors.

## 6. e. Low Vision

**Support for Low Vision Services:** In countries such as Thailand where the Crown Princess is deeply involved in disability work it has accelerated the work for low vision. In Bangladesh, low vision services for children has been integrated into the childhood blindness programmes.

However in most settings, low vision continues to get low priority. It requires political will to bring it to the forefront of the Vision2020 agenda of each country.

**Poor Focus on Low Vision:** Low vision care is usually required for persons with multiple disabilities (this usually leads to their visual status being ignored). Many children with low vision are wrongly labelled blind and are currently not enrolled in schools. It is observed that 25% of all children in blind schools close to have low vision.

**Critical Partnerships:** Low vision requires a multidisciplinary approach. This requires linkages across many professional areas: education, welfare and benefit schemes, rehabilitation, ophthalmologists and counselling. Requires networking for management and treatment - primary to tertiary levels

It is necessary that we advocate for inclusion of the other services that are required by low vision patients (such as rehabilitation, support for education and specialised vocational training).

Eye care professionals have to be appropriately sensitised. There is still poor awareness of low vision care among even eye care professionals. This results in low referrals. There should be established protocols for such internal referral.

Standard data collection should be established along with surveillance systems. Successful models of service delivery should be documented and shared.

**Human Resource:** It is essential to build the highly nuanced competence that low vision demands. Thailand has instituted a college at the national level college that trains manpower for low vision service. It also trains disabled persons. Each of our eye care organisations can also be part of the change by employing visually disabled persons.

Ophthalmologist training alone is not sufficient. Training should encompass the entire range of personnel who should be engaged in providing low vision care: Physicians, technicians, social workers and teachers. Mid-level ophthalmic personnel should also be oriented to this work. Low vision care is technician-intensive and there is a need for refractionists and rehab personnel as well.

**Low Vision Aids:** The Hong Kong Low Vision Resource Centre is a collaboration that sources low cost low vision aids from around the world and makes it available at a central distribution centre.

However there is a stigma associated with the use of these devices and hence results in poor compliance among patients.

## 7. Human Resources

Currently there is a huge gap between the need for trained manpower and actual availability and this holds true across all cadres of eye care workers. Also, the spread of HR is uneven and concentrated in urban areas.

**Building competence:** There is a very strong correlation between the availability of HR capacity and the outputs and this is reflected in the prevailing Cataract Surgical Rates. Availability of adequate ophthalmologists is an issue the most of the countries.

Competency of ophthalmologists should be ensured. Training should be focused towards this. Of the 800 ophthalmologists in Bangladesh, about 50% only perform surgeries. Right now, ophthalmologists prefer to work in the capital city or bigger institutes. Government of India has made a policy to increase the number of seats every year – by 1/3 of the annual intake. In addition to this, there is an increase in the intake of postgraduate seats.

We don't have exact data about the current availability of various categories of eye care professional at the State level. This would help in better HR capacity planning and training needs. Similarly, a uniform curriculum and is not available for paramedic staff is not available right now. Having in place a uniform accreditation and curriculum could be progressive for HR development. Training should be standardised and outcomes should be clearly defined.

In Indonesia there are about 150 ophthalmologists which is only one fifth of the need. The country requires at least one ophthalmologist per district. The national action plan focuses on increasing the human resources capacity of all categories and increasing the quality of participating institutions involved in training.

**Retention:** Retention of eye care personnel in all cadres remains an issue in most countries. With respect to the ophthalmic nurses, the key issue is their retention, especially in the government set up.

There are three centres that train eye care personnel in Myanmar. Some have to train abroad and most of those who do FRCS in England do not return. Some of them join the private sector. Efforts are taken to motivate the ophthalmologists in the private sector to volunteer and give their time and perform surgeries in the government hospitals.

**Distribution:** Distribution of ophthalmologists is a key issue. It very difficult to attract doctors in the rural areas; initiatives beyond cataract services should also be considered to ensure adequate facilities are there such as specialty eye care and training work that would motivate people to remain.

In Nepal, there is a rural university that has the intake of rural students. This may enable sufficient supply of manpower to rural areas.

There has been always a problem to understand the current capacity of human resources. There is a need to develop a dynamic HR MIS that would give a real picture.

**Specific action points:**

- There is a need to have a regional consultation to address HR issues. HR capacity should be developed based on the estimated workload for each of the countries. Training policies and facilities should be built based on this.
- Already a lot of exchanges are happening across the countries. WHO Regional Office may look into this to take it forward.

## 8. Monitoring

There is a great need to create a monitoring system that not only reports the data but feeds into a live feedback system that serves to continuously improve actions taken – by way of assessing resources available and identify areas where improvement is needed.

*“One cannot recognize, understand, improve or maintain what one does not measure.”*

- Robert S. Kaplan

**Creating the Monitoring System:** This includes the selection of indicators and standards or benchmarks for these measurements. Data collection should be designed for reliability and efficiency. The collected data should be analyzed to evaluate performance and compare against the established plan.

Monitoring surfaces barriers in implementation of the programme, and offers opportunities to suggest remedies and in some cases to reset relevant goals and objectives. It is one of the essential building blocks of an effective health system.

In India, the Indian national government database being developed will be a milestone, because we will be able to get disaggregated data to monitor performance. But this will capture only limited data – it does not capture data regarding surgeries which are not supported by the government.

It is essential to encourage sharing of data in a public way. It is essential to develop a platform that enables an easy and secure way of sharing data.

*“It is important that whatever data is collected is used. We do not want to have a tsunami of data. We should not spend resources collecting data that is not being used.”*

- Dr Pararajasegaram

The importance of data is in strengthening individual services. They should use the data to improve their programs. Just publishing data is not of much use. The other concern is on the quality of data. To make sure that all our efforts are not wasted, we need to ensure that the data is of good quality. If people do not see the value of entering the data, then they may not pay attention to the quality of data entry. This can be enhanced by allowing the users of the data to collect, analyse and act upon it.

## 9. Annexure

**a. Videos:** Videos of the presentations made by the speakers are available for viewing [here](#).

### b. Participant List

No	Name	Designation	Organization	Country
1	<b>Dr. Abu Raihan</b>	Senior Program Advisor	ORBIS	Asia Region
2	<b>Prof. Deen Md. Noorul Huq</b>	Director	National Institute of Ophthalmology	Bangladesh
3	<b>Dr Mostafa Zaman</b>	National Professional Officer	World Health Organisation	Bangladesh
4	<b>Dr Nor Tshering</b>	Ophthalmologist	VISION 2020	Bhutan
5	<b>Ms. Sujaya Krishnan</b>	Joint Secretary	Ministry of Health	India
6	<b>Dr. Col Deshpande</b>	President	VISION 2020	India
7	<b>Dr. G.V. Rao</b>	Executive Director	VISION 2020	India
8	<b>Mr. Pankaj Vishwakarma</b>	Head of Programme Development	Sightsavers International	India
9	<b>Mrs. B. Gunawathy Fernandez</b>	Regional Director	CBM South Asia Regional Office	India
10	<b>Dr. R.V. Ramani</b>	Founder & Managing Trustee	Sankara Eye Hospital	India
11	<b>Dr R R Sudhir</b>	Head Dept of Preventive Ophthalmology	SankaraNethralaya	India
12	<b>Dr Padmaja Kumari Rani</b>	Consultant	L V Prasad Eye Institute	India
13	<b>Mr. R D Thulasiraj</b>	Executive Director	LAICO	India
14	<b>Dr. Allya Alwi Alhabsyi</b>	Staff	Directorate of Basic Health Care	Indonesia
15	<b>Dr. Syumarti</b>	Representative from National Committee on prevention of avoidable Blindness Committee	Cicendo hospital	Indonesia
16	<b>Dr Hernani Djarir</b>	National Program Officer Non Communicable Diseases	World Health Organisation	Indonesia
17	<b>Dr. Khin Nyein Lin</b>	Deputy Director (Prevention of Blindness)	Department of Health	Myanmar
18	<b>Dr. Mohan Bajracharya</b>	Director	Nepal Eye Hospital	Nepal

No	Name	Designation	Organization	Country
19	<b>Dr. Gopal P Pokharel</b>	Technical Advisor	LCIF	Nepal
20	<b>Dr SunuDulal</b>	Technical Advisor	Nepal Netra Jyoti Sangh	Nepal
21	<b>Mr. Y D Sapkota</b>	Programme Coordinator	Nepal Netra Jyoti Sangh	Nepal
22	<b>Dr Shailesh Upadhyay</b>	National Professional Officer	World Health Organisation	Nepal
23	<b>Dr. Reeta Gurung</b>	Medical Director	Tilganga Eye Centre	Nepal
24	<b>Dr. Arumugam Ketheswaran</b>	Regional Director of Health Services	RDHS	Sri Lanka
25	<b>Dr. Palitha Gunarathna Mahipala</b>	Additional Secretary to the MoH National Focal Point for V2020	Ministry of Health	Sri Lanka
26	<b>Dr. Asela P Abeydeera</b>	National Secretariat	VISION 2020	Sri Lanka
27	<b>Dr. Sunil Fernando</b>	Country Director	Sightsavers International	Sri Lanka
28	<b>Mr. Chinthaka Jayanath</b>	Project Administration Officer	International Centre for Eyecare Education Sri Lanka	Sri Lanka
29	<b>Dr. Saichin Isipradit</b>	Deputy Director	Mettapracharak Hospital Department of Medical Services Ministry of Public Health	Thailand
30	<b>Dr. Puwat Charukamnoetkanok</b>	Director of International Affairs Department of Medical Services	Mettapracharak (WatRaiKhing) Hospital Ministry of Public Health	Thailand
31	<b>Ms. Daliah Moss</b>	Director	External Affairs	Timor Leste
32	<b>Dr. Pararajasegaram</b>	Member, Board of Trustees	Sightsavers International	UK
33	<b>Dr. Sara Varughese</b>	Programme Manager	World Health Organization	Regional Office for SEAR
34	<b>Dr. R.D. Ravindran</b>	Co - Chair (India) (Chairman Aravind Eye Care System)	IAPB	SEARO

# Participants Group Photo



## c. Programme Schedule

Day One: September 22, 2011 (Thursday)		
Time	Session	Resource Person
09.00 - 10.00am	Inauguration	
09.00 - 09.02am	Prayer Song	
09.02 - 09.10am	Welcome Address	Dr. P. Namperumalsamy
09.10 - 09.12am	Lighting of the Lamp	
	Setting the Context of the Workshop	
09.12 - 09.20am	IAPB Perspective	Dr R.D. Ravindran Chairman - AECS and Co Chair IAPB-SEAR
09.12 - 09.25am	WHO Action Plan	Dr Sara Varghese
09.25 - 09.35am	Workshop Design	Mr R D Thulasiraj
09.35 - 09.45am	Workshop Overview	Preethi Pradhan
09.45 - 10.00am	Self Introductions	Participants
10.00 - 10.30am	Group Photo and Break	
10.30 - 12.30pm	Member States presentations on the implementation of the Action plan for the prevention of blindness and visual impairment <b>Moderator:</b> Dr Pararajasegaram	Prof. Deen Md. Noorul Huq Director, NIO, Bangladesh
		Dr Nor Tshering Ophthalmologist VISION 2020, Bhutan
		Ms. Sujaya Krishnan Joint Secretary, Ministry of Health, India
		Dr. Allya Alwi Alhabsyi Directorate of Basic Health Services, Indonesia
12.30 - 13.30pm	Lunch	
13.30 - 15.00pm	Member States presentations on the implementation of the Action plan for the prevention of blindness and visual impairment <b>Moderator:</b> Dr Pararajasegaram	Dr. Khin Nyein Lin Deputy Director (Prevention of Blindness) Department of Health, Myanmar
		Dr. Mohan Bajracharya Director, Nepal Eye Hospital, Nepal
		Dr. Palitha Gunarathna Mahipala Sri Lanka
15.00 - 15.30pm	Break	
15.30 - 16.15pm	Member states presentations as above <b>Moderator:</b> Dr Pararajasegaram	Dr. Saichin Isipradit Deputy Director Mettapracharak Hospital Department of Medical Services Ministry of Public Health, Thailand
		Dr Marcelino Correia Chief Ophthalmologist National Hospital, Timor Leste
16.15 - 17.30pm	Group discussion on achievements and gaps in action plan - country wise	

Day Two: September 23, 2011 (Friday)		
07.30 – 08.30am	Hospital Visit (Optional)	
08.30 - 09.30am	Report back by each country	
09.30 - 10.30am	Synergizing with primary health care- Bhutan and Thailand, Stand alone primary eye care, India 30 minutes <b>Moderator:</b> Dr. Sara Varughese	Dr Nor Tshering Ophthalmologist - VISION 2020, Bhutan Dr. Puwat Charukamnoetkanok Director of International Affairs - Mettapracharak (WatRaiKhing) Hospital, Thailand Dr.Padmaja Kumari Rani Consultant - L V Prasad Eye Institute, India
10.30 – 11.00am	Break	
11.00 - 11.45am	Childhood Eye Care <b>Moderator:</b> Dr. SaichinIsipradit	Dr. Abu Raihan Senior Program Advisor ORBIS Asia Dr. Reeta Gurung Medical Director - Tilganga Eye Centre, Nepal <u>Panellists:</u> 1. India 2. Sri Lanka
11.45 - 12.30pm	Refractive Error <b>Moderator:</b> Prof.Deen Md. NoorulHuq	Dr. Arumugam Ketheswaran Regional Director of Health Services - RDHS Sri Lanka R.D. Thulasiraj Executive Director - LAICO, India <u>Panellists:</u> 1. Timor Leste 2. Indonesia
12.30 – 13.30pm	Lunch	
13.30 - 14.00pm	Low Vision <b>Moderator:</b> Dr. R.V. Ramani	Ms. Gunawathy Fernandez Regional Director CBM SARO, India <u>Panellists:</u> 1. Thailand 2. Bangladesh
14.00 - 14.45pm	Cataract <b>Moderator:</b> Dr. Palitha Gunarathna Mahipala	Ms. Sujaya Krishnan Joint Secretary, Ministry of Health, India Dr. Syumarti Indonesia <u>Panelists:</u> 1. Myanmar 2. Bhutan
14.45 - 15.30pm	Diabetic Retinopathy <b>Moderator:</b> Dr. Gopal P Pokharel	Dr. Asela Sri Lanka <u>Panellists:</u> 1. Bangladesh 2. Indonesia
15.30 - 15.45pm	Break	
15.45 - 16.30pm	Country level group discussion	

Day Three: September 24, 2011(Saturday)		
09.00 – 10.30am	HR <b>Moderator:</b> Dr Abu Raihan	Dr. Gopal P Pokharel Technical Advisor, LCIF, Nepal  <u>Panellists:</u> 1. Dr. R D Ravindran, India 2. Dr. Deen Md. Huq, Bangladesh 3. Dr Hernani Djarir, Indonesia
10.30 – 11.00am	Break	
11.00 – 12.30pm	Monitoring <b>Moderator:</b> Mr. R.D. Thulasiraj	Mr. Sunu Dulal Programme Coordinator, Nepal Netra Jyoti Sangh, Nepal  Ms. Sujaya Krishnan Joint Secretary, Ministry of Health, India
12.30 - 13.30pm	Lunch	
13.30 - 14.30 pm	Group work on Strengthening national structures, plans, policies and comittments, monitoring, priorities for SEAR	
14.30 - 15.30pm	Presentations	
	Next steps to the workshop and Valedictory	
15.30 - 16.00pm	Refreshments	

