

Summary report on the

**Regional workshop for integrating and
strengthening primary eye care within primary
health care in the Eastern Mediterranean Region**

Dubai, United Arab Emirates
14–16 February 2011



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. Introduction

In order to improve eye health and prevention of blindness activities in the Region under the renewal of primary health care reform as recommended in the World Health Report 2008; the WHO Regional Office for the Eastern Mediterranean organized a regional workshop on integrating and strengthening eye health within primary health care (PHC) in the Eastern Mediterranean Region from 14 to 16 February 2011 in Dubai, United Arab Emirates. Participants from 21 Member States attended the meeting, including regional and international experts and representatives from nongovernmental organizations and collaborating centres. The workshop was held in collaboration with the Ministry of Health of the United Arab Emirates; Dubai Health Authority, the International Agency for the Prevention of Blindness, IMPACT-EMR, Sightsavers and Noor Dubai.

The World Health Assembly adopted two resolutions WHA56.26 and WHA62.1 on the elimination of avoidable blindness and the prevention of avoidable blindness and visual impairment, respectively. Subsequently, in 2009, the Sixty-second World Health Assembly endorsed a resolution and also plan of action for blindness prevention, requesting Member States to implement the action plan for the prevention of avoidable blindness in accordance with national priorities and within the primary health care approach. However, despite significant progress in the area of eye health care, there are still many countries and communities where the prevalence of avoidable blindness is unacceptably high.

- Although eye care is an integral part of health care system, eye health has not always been sufficiently integrated at all levels of health care delivery, especially in PHC and in health financing;

- There is increasing evidence that the prevalence of ocular morbidity is quite high and this could be addressed through a “comprehensive eye care” system development approach, as emerging causes are to be dealt with at tertiary level, but many of the existing avoidable causes can be addressed at primary level effectively.
- Many policy-makers are not fully aware of the benefit of integrating eye health within PHC and the health system, resulting in poor priority assigned to the development of the eye care system and eye care service financing.

In his message, Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, stressed that early detection and treatment of common blinding diseases through community and primary health care within the health system would have a tremendous impact in improving eye health care delivery and prevention of blindness programme in many Member States in the Region.

Dr Ahmed Trabelsi was elected as Chairperson for the meeting. Dr Haroon Awan, Dr Rajiv Khandekar and Mr Niaz Ullah Khan were appointed as Rapporteurs.

2. Conclusions

Universal coverage

There are certain groups in the Region at risk of not having adequate access to health services. These include people with disabilities and low socioeconomic status, the elderly, those living in remote areas where there is unavailability of health staff and equipment, those living in urban slums or conflict areas, self-employed – immigrants or non-

residents working in the informal sector facing cultural and tribal barriers and gender sensitivities, illiterate people who lack information and communities with poor transportation facilities and lack of health insurance coverage.

This is further compounded by a lack of health awareness, mistrust of health care facilities, inappropriate health care services, informal payment (tips) even where treatment is free, high indirect costs, unaffordability of health care services and poorly-organized PHC services.

Various social protection mechanisms exist in the Region. These include coverage of health care by government, existence of pre-payment and health insurance schemes and health care delivery by nongovernmental organizations, the private sector or United Nations agencies.

Service delivery

It is noted that there are two main types of models/approaches operating within the Region. The model prevalent in most members countries of the Gulf Cooperation Council (GCC) and North African countries is a family practice approach, which is located at a static health facility, e.g. health centre and staffed by family doctors, general practitioners, nurses and health inspectors. They provide a comprehensive PHC service with diagnostic facilities and referral to district hospitals or specialist centres. In some countries PHC centres exist that may include an eye specialist.

In other low- to medium-income or densely-polluted countries, the model for PHC is derived from a community- or volunteer-based service

in which the community health worker is a resident of the community that they serve and their house is usually designated a health house. They cover a defined unit of population. Many community health workers are female. They may be salaried staff or community volunteers.

Most eye problems encountered in either model/approach can be classified under three categories: impaired vision, red eye and eye injury. In more advanced PHC service delivery models, a more sophisticated approach to service delivery is needed, e.g. detection and diagnosis of diabetic retinopathy in communities with a high prevalence of metabolic disorders and obesity.

The variation in availability of technology and health staff at static facilities determines the extent of diagnosis and treatment available under a PHC service. Similarly, information management of eye health problems varies considerably depending on availability of information communication technology (ICT) and trained staff. In PHC services with well-developed ICT systems for data management, considerably more eye health indicators could be obtained from PHC services.

Public policy

PHC is a cross-cutting health strategy that rests within the framework of health and related public policies. It plays a key role in linking health and development. The regulatory framework for PHC varies within countries of the Region as does the level of basic unit of coverage. Key policies that have an impact on PHC include health, education, social protection, environment, nutrition, water and sanitation, etc. However, there is very little coordination of such policies for PHC.

The social determinants of health, especially poverty, ignorance, education, are contributing factors for the low uptake of eye care at the community level. In addition, there are resource constraints for uptake of eye health in some countries, especially availability of adequate human resources, finances, infrastructure, etc. Those implementing PHC and eye health programmes often do not appreciate the inextricable link of PHC with the wider development agenda of the Millennium Development Goals and Poverty Reduction Strategy Papers with the result that resource allocation for PHC programmes does not match its vital importance to health and development.

Most PHC programmes are unaware of the community-based rehabilitation guidelines launched by WHO, the International Labour Organisation and the United Nations Educational, Scientific and Cultural Organization (UNESCO) and therefore are unaware of how these can add value and promote intersectoral collaboration while developing PHC programmes incorporating eye health.

Leadership and governance

Eye health indicators are not fully embedded in national health management information systems. This means that national health reports reaching policy-makers and health planners do not adequately reflect the burden of eye disease nor highlight the health care visitations due to eye problems.

Almost all countries in the Region have functional national committees for prevention of blindness but there is little collaboration with the PHC programme. In those countries with advanced PHC systems, eye health is integrated to a certain extent, but there is no

evidence of joint planning, monitoring and evaluation between programmes. Similarly was the case with the national HMIS programme.

It is not apparent that both eye health and PHC programmes have been sufficiently oriented about the new WHO health systems framework and primary health care reforms. Thus, planning and interventions by both programmes do not appear to have adopted a systems approach or to have aligned programmes with health systems strengthening.

There is insufficient understanding by both PHC and eye health programmes of health policy and planning processes and the implications of these on health programmes. There is very little evidence of regular interaction of national coordinators of both programmes with health planners and policy-makers to understand policy needs. Similarly, national programme managers do not adequately understand health financing and budgeting processes which hinders advocacy efforts to mobilize more resources.

Health workforce

The delivery of PHC in the Region is provided by a variety of cadres in different settings of service delivery. These include family physicians, general practitioners or medical officers, nurses, midwives, health inspectors, vaccinators and community health workers. In some instances, even optometrists and ophthalmologists are part of the PHC team.

Physicians working in PHC services are mainly responsible for diagnosing and treating common non-vision impairing conditions, and diagnosing and referring vision impairing conditions. Nurses are involved only in vision testing, instilling of eye medication and providing first aid.

Community health workers are trained to check vision and refer those with impaired vision to the next appropriate level of care. In low- to medium-income countries, community health workers are also permitted to dispense antibiotic eye ointment as part of their PHC kit.

The training of physicians in eye health ranged from 2 months for family physicians to one week in-service courses for general practitioners and medical officers, even though the tasks that they perform are similar in many instances. Nurses and community health workers usually receive 1 to 2 days of orientation in eye health. In some countries, triage nurses filter eye patients who visit health centres. Refresher training for all cadres providing eye health as part of PHC is unusual. Health educationists are also part of the PHC team but are not providing eye health promotion.

Most eye conditions that the PHC health workforce has to deal with fall into the following three categories: impaired vision, red eye (commonly due to conjunctivitis, allergies, dry-eye, etc.) or eye injury. There is a direct relationship between these three thematic categories of eye problems to the knowledge, skills and competencies required by PHC staff for eye health, and also for health information needs for eye health at PHC level.

School health

There are various types of school health programmes in the Region. These vary from nutrition, mental health, oral health, ear health, eye health to adolescent health programmes. There is great diversity in who provides school health. The range of cadres include general practitioners/family physicians, nurses, vaccinators, optometrists, preventive doctors, nutritionists, dentists, community-based rehabilitation

workers, teachers, students, PHC staff and ophthalmic technicians. This implies that it is quite challenging to develop a standardized curriculum. Furthermore, school health programmes are either being led by the ministry of health or ministry of education.

Key knowledge and skills required by school health staff for eye health include vision screening, first aid for eye emergencies, red and sticky eyes, eye strain (asthenopia), strabismus, learning disabilities, eye health promotion and counselling skills. A curriculum for school health is not uniformly available for all cadres and all school health programmes. The school eye health programmes demonstrate considerable variation in implementing methodologies within the Region, and especially the use of health promotion materials.

While there is a practice of school screening in some countries, there is no standard practice of screening programmes for children to detect and prevent visual impairment, i.e. vision certificate, such as immunization cards, etc.

3. Recommendations

The integration of primary eye care/eye health in primary health care is recommended in all Member States of the Region. This should be carried out simultaneously while strengthening both primary eye care/eye health and primary health care. In establishing the integration process, the four components of primary health care reform need to be considered for the adoption of a holistic approach.

To Member States

Service delivery

1. Plan the integration of eye health in primary health care in the context of country-specific operating models and customize for maximum synergies depending on their level of development and health need.
2. Focus on adopting a programme approach in eye care delivery through PHC, including monitoring and evaluation mechanisms to address impaired vision, red eye and ocular trauma.

Health workforce

3. Prepare and implement a training programme about primary care that is suitable for local needs for PHC staff.
4. Review and refine curriculae of cadres providing eye health in primary health care in those countries in which a degree of integration already exists to enhance integration. Where such integration is not yet available, develop new and appropriate training programmes jointly with key stakeholders (including professional bodies where necessary) and incorporate in wider human resources for health planning.

Universal coverage

5. Identify population groups that are not covered by existing services and remain vulnerable. Undertake socioeconomic and

health coverage studies to obtain disaggregated data for these population groups.

Health financing

6. Introduce financing mechanisms in the form of health insurance, community pre-payment schemes or other modalities, including pooling of tax incomes, etc. to subsidize patient fees.

Public policy

7. Conduct research to establish the burden of eye disease in communities and its socioeconomic impact on primary and secondary health services to determine the implications on health policy.

Health management information system

8. Undertake joint planning, improved data management, analysis, monitoring and evaluation at district level in primary health care and eye health programmes to address service utilization inequalities and inequities related to eye health. This can be done actively engaging national health management systems to review and refine collection and reporting of eye health indicators.

Leadership and governance

9. Include representatives of primary health care programmes and national health management information systems as members on national committees to promote collaboration between programmes.

10. Appoint national coordinators of eye health/prevention of blindness and allocate an appropriate budget for integrating eye health in primary health care. Appoint district managers responsible for integration of primary eye care within primary health care and health systems.
11. Undertake joint consultation meetings and review of eye health in primary health care programmes periodically. Such joint reviews guide decision-making on matters relating to consumables, technology and referral pathways.

School health

12. Implement the recommendations of the WHO/IAPB document on “Guidelines for school health for the Eastern Mediterranean Region”.
13. Develop action plans for short-, medium- and long-term goals in countries already implementing school health programmes that incorporate eye health, and promote completion of the care cycle (screening, care, provision of spectacles and low vision devices as necessary, monitoring compliance, follow-up and reporting).
14. Establish screening programmes for pre-school children where resources permit, and include development eye checks in primary health care activities during immunization visits.

To international partners

15. Promote and collaborate closely for the integration of eye health within primary health care and the health system.
16. Strengthen advocacy, partnership and support collaboration between institutions and Member States and the Regional Office to implement eye care at all levels of health care delivery.

To WHO Regional Office for the Eastern Mediterranean

17. Assist Member States to develop country-specific plans of action on the integration of eye health in primary health care.
18. Constitute two task forces:
 - Task force on training (eye health in primary health care) – to ascertain what is currently available and develop standardized training modules for the training of primary health care workers in eye health. These training modules can then be adapted by Member States for local use.
 - Task force on data and monitoring – to determine the health information needs for eye health in primary health care and recommend how these may be integrated in existing national health management information systems.
19. Convene a regional workshop, in collaboration with partners, to bring together key stakeholders on school health to learn about good practices, review existing tools and guidelines for eye health in school health, and define a coordinated way forward for the Region.
20. Ensure that future thematic calls by the Regional Office on health research include integration of eye health in primary health care.